

# Out-of-hospital care standards for London's children and young people



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Healthy London Partnership – Transforming London's health and care together

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# About this document

These standards bring together a number of children's standards into one document. We would like to acknowledge the work of the numerous organisations referenced throughout.

These standards have been developed through Healthy London Partnership's Children and Young People's Out of Hospital Standards Group and have since been reviewed by members of Healthy London Partnership's Clinical Leadership Group. There has been consultation with external partners and national bodies. This is a document that will change according to published national and statutory guidance and can be amended accordingly.

We would particularly like to express our appreciation to the following:

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# Introduction

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## Purpose

Healthy London Partnership formed in April 2015. It has been working across health and social care, and with the Greater London Authority, Public Health England, NHS England, London's councils, clinical commissioning groups, and Health Education England. We have united to amplify the efforts of a growing community of people and organisations that believe it is possible to achieve a healthier, more livable global city by 2020. Healthy London Partnership is focused on transformation programmes, one of which is the Children and Young People's (CYP) Programme. Our vision is for an integrated system for health and care services, which promotes health and well-being and can be easily navigated by children, their families and health professionals to achieve the best outcomes.

## Audience

This document is aimed at commissioners and providers of out-of-hospital healthcare services for children. Out-of-hospital care describes any care that is not undertaken in a traditional hospital setting. This could include healthcare in the community, at the patient's home or school or workplace or in a GP practice. This document has brought together information and standards for care into one place to enable the effective commissioning of services that meet these required minimum standards. Providers can use these standards to undertake a self-assessment of their ability to deliver the required quality of out-of-hospital care for children. They can be used to validate, challenge, to quality assure services and improve quality.

## Strategic context

This document is part of a portfolio of products developed by Healthy London Partnership Children and Young People's Programme on out-of-hospital care to drive improvements in quality.

- Out-of-hospital care standards for London's children and young people.
- Compendium: New models of care for acutely unwell children and young people <sup>1</sup> - this document is aimed at commissioners and providers of out-of-hospital healthcare services for children. The compendium brings together models of acute care that can be delivered within ambulatory settings within hospitals or in community and home settings. Many of the case studies included illustrate how these standards can be used to drive improvements in quality and assist commissioners to identify opportunities within their own areas.
- Opportunities for pharmacy to support out-of-hospital care (in development)
- New models of care (in development).

This suite of documents will help organisations to develop place-based models of care treating the children and young people in the most appropriate location for their needs.

## Inclusions

Extensive research was undertaken to identify existing standards. These were taken from a diverse number of sources such as the Royal Colleges, National Guidance/National Institute for Care and Health Excellence (NICE) and the London Quality Standards developed by London Health Programmes as well as Healthy London Partnership's acute standards and asthma standards. There was significant similarity and overlap across many of the standards. Where this occurred, the standards have been worded to capture the essential meaning of the multiple sources. The original sources have been included and cross referenced.

The standards are designed to promote quality and standardisation across London, for out-of-hospital healthcare provision for children and young people. They are aimed at addressing the needs of physically unwell children and young people (with or without a long term condition) or those with continuing/complex care needs, who can receive safe health care at home or in settings outside of hospital. The role of the nurse has been clearly identified in the evidence for out-of-hospital care, but there is a shift and growing body of evidence considering other professions undertaking responsibility for delivering acute health care out-of-hospital, for example community pharmacists and allied health professionals (AHPs).<sup>2, 3</sup>

The standards outlined represent the minimum quality of care that children attending at any out-of-hospital care setting (including in the home) should expect to receive in London. All standards apply to seven day services. There is no difference in the provision of services during the week compared to those at the weekend. All services must meet section 11 of the [Children Act \(2004\)](#) as well as the 2013 document on interagency [Working Together to Safeguard Children](#) (WTtSC).<sup>4, 5</sup>

## Exclusions

All universal child health programmes covering healthy child development and public health are not included (See appendix 4 additional reading for child health surveillance information).

The standards relating to the healthy child programme are detailed in relevant National Frameworks and Service Specifications e.g.

<https://www.gov.uk/government/publications/healthy-child-programme-rapid-review-to-update-evidence>

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/492086/HCP\\_5\\_to\\_19.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/492086/HCP_5_to_19.pdf).

Whilst these standards strive to meet the mental health needs of children and young people who are acutely unwell, it would be important to refer to *Improving care for children and young people with mental health crisis in London* and the Royal College of Psychology Faculty of Child and Adolescent Psychiatry for standards relating to children and young people in crisis.<sup>6, 7</sup>

## Notes

In this document the term children or child should be taken as meaning children and young people from 0-18 years. In line with special educational needs and disabilities (SEND) there is a requirement to consider needs up to the age of 25 years. It takes into account young people who are undertaking transition to adult services. The term multidisciplinary team (MDT) is referenced throughout the document and relates to the many health professionals involved in the care of children as well as the close collaboration with acute services, local authorities, social care and local education. The MDT includes school nursing, general practitioners (GPs), community pharmacy, continuing healthcare nursing, child and adolescent mental health services (CAMHS), psychology, occupational therapy (OT), physiotherapy, dietetics, speech and language therapy, voluntary sector, community paediatric and district nursing teams.

Ensuring family engagement and involvement is central to the implementation of these standards. Where the standards mention parents, this should include parent carers.

When organisations and commissioners are redesigning out-of-hospital services they should consider all members of the primary and community team. For example, community pharmacy can deliver education and training to patients, when they are collecting prescriptions, and staff who work in hospital are able to cross boundaries to provide care to children and families at home.

Services should offer value for money, provision being clinically effective, equitable and cost-efficient. Services should be commissioned over a realistic time frame to allow development of new services and the sustainability of established services. Services should then work within the available resources taking account of economic, social, political and environmental factors.<sup>15</sup>

Services should be able to account for workforce strategy and planning around new roles (e.g. physician's associates, nursing associates and therapy assistants), skill mix and engaging with the local community working population.

Services should be well co-ordinated between the agencies and disciplines involved and provide continuity over a period of time. Pathways of care should be agreed and owned by all stakeholders, including children and families, explicit and clearly written so that access to services is transparent. There should be networking between primary, secondary and tertiary care, facilitating access to specialists' assessment and intervention when appropriate, and providing shared care locally. There should be liaison with local and national voluntary organisations.

Children's service models of working are often very different from those of adult services. Children's services generally focus on the health needs of the child and family, whilst adult health services are organised around clinical systems e.g. respiratory, gastroenterology and neurology. So moving from one service to the other can be a very daunting prospect for young people. Therefore, transition is presented as a key topic in this document.

A comprehensive local Children's Palliative Care (CPC) service spans health, social care and education. It is a whole-family approach and is flexible and focused on children, their

parents and their siblings. CCGs also need to be aware of their duties under the *Children and Families Act 2014* relating to palliative care.<sup>8</sup> There is reference to the standards of care provided within *Together for Short Lives* which provides a comprehensive picture.<sup>9</sup>

Implementation of the *Five Year Forward View*<sup>11</sup>, *Transforming Primary Care in London: A Strategic Commissioning Framework*<sup>37</sup> and *Children and young people's health services in London - A Case for Change*<sup>10</sup> will lead to significant transformation in the way that primary care and acute non-hospital services are delivered for children and young people across the capital. These documents combine to set out a vision for new models of care and service delivery. They describe fundamental changes to the range, consistency and quality of services available to all patients, with a drive to care for them in a non-hospital setting.

All staff working with babies, children and young people must be trained in the safeguarding them.

## Core principles

Children should not be admitted to hospital if it can possibly be avoided and therefore minimize time lost from education. To minimise distress and impact of hospitalisation, admission should be only considered when clinically unavoidable and necessary.

There should be the ability for sharing of information so that families can reduce the number of times they share the child or young person's history.

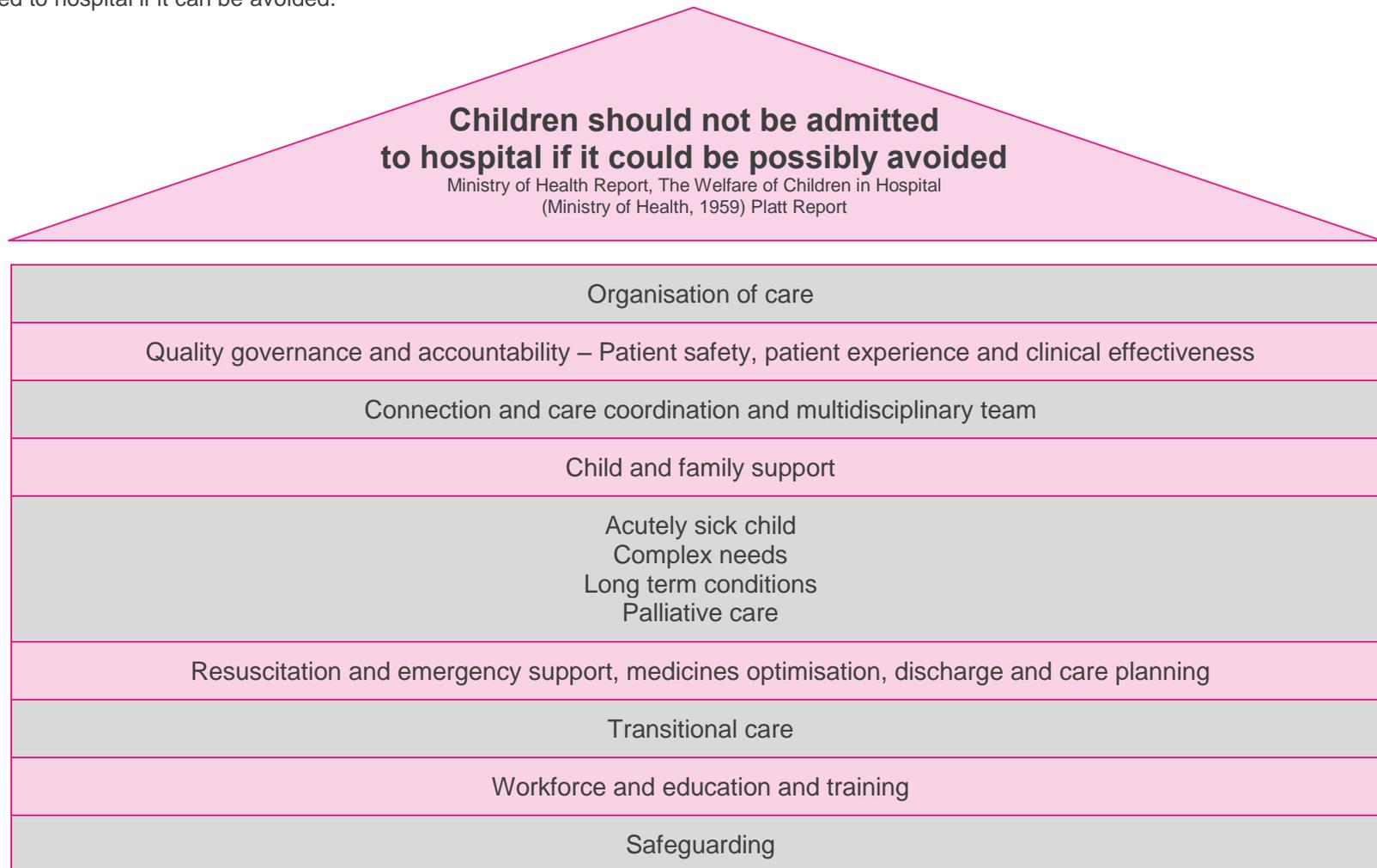
A whole system approach is needed to move health care out-of-hospitals and redesign services for children within community settings, with learning from the [5 year Forward View](#) Vanguards on new models of care.<sup>11</sup> Areas will be establishing place-based 'systems of care' in which they collaborate with other NHS organisations and services to address the challenges and improve the health of the populations they serve.<sup>12,13</sup>

Overall care should be underpinned by the *Children and Families Act 2014*<sup>8</sup> and reflective of the [United Nation Convention on rights of a child](#), (UNCR) which says that every child has:

- The right to a **childhood** (including protection from harm)
- The right to be **educated** (including all girls and boys completing primary school)
- The right to be **healthy** (including having clean water, nutritious food and medical care)
- The right to be treated **fairly** (including changing laws and practices that are unfair on children)
- The right to be **heard** (including considering children's views)

# Framework for out-of-hospital care

This framework represents the scope and contents of the standards of care for out-of-hospital health services based on the principle that children should not be admitted to hospital if it can be avoided.



## A ORGANISATION OF CARE

Every child and young person with healthcare needs has the right to expect care to be provided at home, where it is clinically appropriate and safe to do so. Such care should be timely, high quality and effective at reducing avoidable hospital admissions or attendances.<sup>4,14,22,27, 29</sup>

Organisations and health care systems need to put plans in place and work together to ensure that the care that is provided includes health, education and social care.<sup>12</sup> Care is to be localised where possible and centralised where necessary.

Organisations need to ensure that the children's public health agenda is recognised. All children should have appropriate access to physical care and mental health care preferably managed within one system to ensure parity of esteem. A whole system approach is needed to shift care out of hospitals<sup>14</sup> and re-provide services in the community setting/home, learning from Vanguards on new models of care with the *5 year Forward View*<sup>46, 89</sup>

	<i>Standard</i>	<i>Evidence</i>	<i>Ref</i>
1	<p><b>There should be high level accountability and responsibility within the provider landscape.</b> It is recommended that each provider with services for children has a named executive board member with board level responsibility for children's services. There should be clear accountability from front line to Board.</p> <p><b>The development of out-of-hospital health care service is informed by a local vision for children's services developed and owned by local executive champions.</b> Health and local authority partners should commission services to enable ill and disabled children to maximise wellbeing. The service commissioned is informed by the joint strategic needs assessment and the Children and Young People's Plan/Joint Health and Wellbeing Strategy.</p> <p>Service and workforce plans should be evaluated regularly to ensure they are meeting the most recent evidence, taking into account the evolving needs of the child population and their families and improve the standard of care provided to children and their families.</p>	<p>Named executive or equivalent with board level responsibility</p> <p>Demonstrated in published organisational annual plans</p> <p>Governance structure</p> <p>Terms of Reference, membership and accountability of the group</p> <p>Evidence in minutes of regular discussion at board level</p> <p>Evidence of audit and compliance against relevant standards</p> <p>Self-assessment against HLP OOH standards for children and action plan</p> <p>Evidence that operational policies regarding provision of</p>	<p>15, 16, 17, 18, 19, 20, 35, 36, 44, 47, 70</p>

	There are clear service specifications available that meet NHS standard contract requirements.	children's services are reviewed regularly within governance accountability frameworks Evaluation of service and workforce plans Service specifications available Joint strategic needs assessment (JSNA) Health and Wellbeing Board (HWB) strategy	
2	<p><b>Child health and wellbeing provision needs to include:</b></p> <ul style="list-style-type: none"> <li>➤ An awareness of the rights of the child in line with UNCR (article 12)</li> <li>➤ Primary and secondary prevention</li> <li>➤ Early identification and intervention when problems detected</li> <li>➤ Statutory obligations including early safeguarding and child protection</li> <li>➤ Partnership working with children, young people, parents and carers</li> <li>➤ There should be a clinician for children in each health economy who champions the needs for children in that system</li> <li>➤ There is a link consultant paediatrician for each local GP practice or group of GP practices/network</li> <li>➤ There should be 'open access' - i.e. telephone and email contact between senior child health clinicians across primary and secondary care</li> <li>➤ <a href="#">Healthy Child Programme</a></li> </ul>	Operational policy Children's strategy Policies to include statutory obligations Named clinician in each health economy and job description Named consultant paediatrician in each network/group of GP practices and job description Evidence of shared email and telephone contact details across primary and secondary care Minutes from system meeting where CYP were discussed	18, 21, 22, 23, 34
3	<p><b>This service is provided in accordance with the Equality Act 2010</b> Primary care teams should design ways to reach people who do not routinely access services and who may be at higher risk of ill health.</p> <p>The service is easily accessible by people with any form of physical disability or sensory impairment or mental health issue. Disability support aids are fully functional and freely available to assist sensory impairment.</p>	Service audited against the Equality Act Strategies to target "hard to reach" children's groups Analysis of waiting times and access Service specifications Regular assessment of	24,25,26,37,39,42

	<p>Assessment, counselling and support services are provided to marginalised and socially excluded young people. If specialist services are required, young people are referred.</p> <p>The service addresses health inequalities by monitoring the uptake and outcomes by the protected characteristics and then acting upon the results.</p>	performance in place	
4	<p><b>The commissioned service is informed by clear, locally agreed pathways for the four categories of health needs of children across hospital to home set out below which clearly define the contribution of a Community Children’s Service (includes the role of paediatricians, AHPs and pharmacists) and Community Children’s Nursing Service (CCN):</b></p> <ul style="list-style-type: none"> <li>➤ Children with acute and short-term conditions</li> <li>➤ Children with long-term conditions</li> <li>➤ Children with disabilities (with health needs) and complex care needs, including those requiring continuing care</li> <li>➤ Children with life-limiting and life-threatening illness, including those requiring palliative and end-of-life care</li> </ul>	Evidence of agreed pathways	14,19, 20
5	<p><b>All children requiring nursing care should have access to a CCN service, staffed by qualified children’s nurses with the appropriate competencies, wherever they live to enable parents/families to care for their child at home.</b></p>	Case notes showing qualified CCN for all children requiring one	14,22, 27, 28, 89
6	<p>Timely, high quality, appropriate and effective care to be delivered closer to the home/community.</p>	Case notes showing location of care delivery	22,29, 89
7	<p>Packages of care should be provided which co-ordinate health, social care and education in a way that meets the individual and on-going needs of the children and their families.</p>	<p>Evidence that care packages cover health, social care and education</p> <p>Evidence that care packages are regularly reviewed</p>	19, 89
8	<p><b>There is access to diagnosis-specific advice and guidance</b> (for example, access to specialist nurses and therapists (AHPs) and community children’s nurses who have a special interest or responsibility). This equally applies to acute models of hospital at home or virtual ward for children. Hospital at Home provides safe, high-quality, hospital-level care to patients in the comfort of their own homes. The Virtual Ward operates in the same way as a normal hospital ward; the difference is the patient stays comfortably and safely in their own home.</p>	<p>Portfolio of specialist nurses and AHPs available</p> <p>Children’s asthma nurse in locality (building healthy community)</p> <p>Directory of services (e.g. inclusion in MiDoS) of diagnosis specific specialists</p>	14,19, 43

		(including specialist nurses and CCNs with a specific interest of responsibility)	
9	<p><b>A good CCN service has the following attributes</b> (This equally applies to acute models of hospital at home or virtual ward for CYP):</p> <ul style="list-style-type: none"> <li>➤ Consistency of care across environments and professionals; clarity of level of autonomy, accountability and responsibility within the teams</li> <li>➤ A comprehensive service with integrated and coordinated locality care that caters for all four groups of children; the service is responsive and flexible to local population needs and accessible seven days a week, with 24-hour provision on-call service. Analysis of peak activity should determine operational hours of CCN services with requirements for appropriate escalation plans if service is less than 24 hours</li> <li>➤ Robust workforce planning and development and the innovative use of critical mass of workforce within a locality; the right people with the right skill (across all professions and across all hours of operations)</li> <li>➤ Close links with the hospital to allow early discharge and home review (7 days /week)</li> <li>➤ Good working relationship with local GPs and other services who play a crucial role in the communication, relationship building and management of protocols of care, referral pathways and out-of-hours care arrangements</li> <li>➤ Includes therapeutic play support for the child and any siblings where appropriate</li> <li>➤ Timely access to medicines in primary care especially upon discharge from acute settings and at weekends and evenings and including specially formulated medicines for children e.g. suspensions</li> <li>➤ Timely access to advice on the safe storage, use or administration of medicines from a pharmacist</li> <li>➤ Access to emergency supply of medicines and advice on medicines from a pharmacist in an “urgent” situation such as OOH prescribing</li> </ul> <p>There are a number of different models, which are good examples of a CCN service. Increasingly teams include AHPs and other professionals. (See <i>Compendium of new models of care for acutely unwell CYP</i><sup>1</sup>)</p>	<p>Service specifications Operational policy</p>	<p>14,19, 20, 28, 30, 31, 32, 88</p>

10	<p><b>Out of hospital services should provide 24/7 access to advice and support for families and carers and, in end-of-life care, 24-hour visiting as required.</b> The findings suggest a service is needed for children at home between 8am–10pm 7 days a week with telephone advice out of these hours. To be provided by people who are knowledgeable about community children’s services and the individual child, with the ability to make a home visit if necessary.</p>	<p>Analysis of activity against operational hours Operational hours advertised on public website Patient information leaflets showing operational hours Escalation policy</p>	14,19, 20, 21, 28, 33, 43
11	<p><b>The Service is locality and community focussed and therefore should be delivered from appropriate locations (accessible by public transport where there is a choice) and within suitable accessible settings, including the service user’s home/place of residence</b></p>	<p>Patient experience survey of suitability of location</p>	14, 26, 34, 39
12	<p><b>Children should be seen and assessed in suitable accommodation</b> (environment, equipment, access to staff) whether at a health centre, children’s centre, local hospital, school or at home.</p> <ul style="list-style-type: none"> <li>➤ The standards defined by the Royal College of Paediatrics and Child Health (RCPCH) are applicable to any paediatric consultation in any location</li> <li>➤ The reception, waiting and treatment areas are accessible, young people friendly, comfortable and welcoming</li> <li>➤ There is a range of recreational activities appropriate for children and young people for example toys, reading material and multimedia and these are refreshed regularly. In accordance with Health and Safety Regulations, these are maintained and kept in working order</li> <li>➤ Young people are not asked any potentially sensitive questions where they may be overheard for example in the reception, waiting areas or ward environment</li> <li>➤ All staff routinely explain who they are, and what they/the service can and cannot provide to help</li> <li>➤ The service considers the physical and cognitive ability of the child/young people and takes into account the effects of sedation, analgesia and mental health state</li> </ul>	<p>Audit of all areas where children receive care against RCPCH accommodation standards Operational policy Assessment against the Department of Health’s (DH) <i>You’re Welcome Criteria</i> Patient experience questionnaires</p>	15, 35, 39 You’re welcome being updated
13	<p>Clear multi-disciplinary <b>protocols</b> are in place to:</p> <ul style="list-style-type: none"> <li>➤ Facilitate/support access to hospital care when necessary for children who have complex care needs and are normally cared for at home</li> <li>➤ Support hospital and community staff when such children require</li> </ul>	<p>Operational policy or standard operating procedures where evaluation is needed</p>	19,20, 85

	<p>admission to hospital to ensure the child is looked after by safe competent staff in the hospital environment</p> <ul style="list-style-type: none"> <li>➤ Enable the multi-disciplinary professionals to seek advice and to make referrals where appropriate to other members of the integrated team (for example, physiotherapists)</li> <li>➤ Enable joint working and undertake shared care planning</li> </ul> <p>This standard equally applies to acute models of hospital at home or virtual ward for children.</p>		
14	<p>Where a child or young person is admitted to a Hospital at Home or Virtual Ward then the following standards should apply:</p> <ul style="list-style-type: none"> <li>➤ They are seen by a clinician with the relevant competencies within four hours</li> <li>➤ They should have access to a clinician with the relevant competencies throughout all the hours they are open</li> </ul>	Operational policy Audit of notes	36
15	<p>Access to consultant paediatrician rapid access advice for any child requiring hospital at home or virtual ward is available within 24 hours of assessment.</p> <p>Appropriate escalation of care in place for deteriorating children</p>	Operational policy Audit of notes	19, 21
16	<p><b>Children and parents should be given a choice of access options</b> and should be able to decide on the most appropriate service to meet their needs. For example a child requiring regular venepuncture should be able to choose whether they have it at school, home, at the GP or in outpatient clinics.</p> <p>Young people can use the service at times convenient to them where possible.</p>	Patient and family experience survey Audit of notes Directory of service availability and opening hours	37, 38, 39
17	<p>When making appointments and attending consultations, young people may express a preference about:</p> <ul style="list-style-type: none"> <li>➤ Where they are seen</li> <li>➤ Who they are seen by</li> <li>➤ Attending with the support of a friend or partner</li> <li>➤ Who and how many people are present during discussion, examination and treatment</li> <li>➤ The gender of the member of staff they are seen by</li> </ul> <p>It is fully recognised that these standards are aspirational.</p>	Patient experience survey Audit of notes	39
18	<p><b>Young people are routinely offered the opportunity to be seen on their</b></p>	Patient experience survey	36, 39, 40, 41, 44

	<b>own without the presence of a parent or carer.</b> This should be assessed through Fraser Competence and Safeguarding Needs. The service ensures young people's privacy and dignity are maintained during discussion, examination, treatment and care. This includes access to chaperones as required.	Audit of notes	
19	<b>Patients should be required to only make one call, click or contact in order to make an appointment.</b> Primary care teams should maximise the use of technology and actively promote online services to patients including appointment booking, prescription ordering, viewing medical records and email consultations.	Patient experience survey Audit of notes	37
20	<b>Services should be both accessible and family friendly.</b> They should however be the best for that individual child with a particular condition even if it means the child and family need to travel to reach the specialist in that field; in these cases care should be delivered within a network, ensuring the child has access to the services and expert opinion they need and delivered in a timely manner. Waiting times should be monitored.	Operational policy Waiting times monitored Evidence of network working	15
21	<b>Services should address the needs of the child/family holistically and consider physical health within mental health services and mental health within physically focused services.</b>	Review of case notes Evidence of participation in MDT for mental health workers	6, 15
22	<b>Participation of young people in planning and refining the service,</b> formally or informally, individually and collectively, is crucial to ensuring good care. Primary care teams should work with communities, patients, their families, charities and voluntary sector organisations to co-design approaches to improve the health and wellbeing of the local population.	Evidence of young people's involvement in planning - minutes of meetings/ workshops	14,18, 37, 42
23	<b>The community children's service and families should have access to equipment to enable sustained home support.</b> <ul style="list-style-type: none"> <li>➤ The family should be given all equipment and aids appropriate to the child's needs and age</li> <li>➤ All medical equipment is the correct size and specification for use on children. Its design is tailored to meet the different needs at different ages and stages of development</li> <li>➤ There should not be undue delays in providing or repairing equipment; if delay is unavoidable, the family should be kept informed</li> </ul>	Patient experience survey Waiting times key performance indicators (KPIs)	14,20, 35, 43, 44, 45, 47, 70

24	<p><b>The GP/primary care team is best equipped to help a family navigate the system, contextualise commissioning decisions and be responsible for holding and maintaining all health-related information about a child or young person, often within the wider context of knowing the family and its background.</b></p> <p>All patients should be registered with a named clinician who is responsible for providing an on-going relationship for care coordination and care continuity. Practices should provide flexible appointment lengths as appropriate.</p>	Named clinicians for children and job description	18, 19, 37, 46
25	There is a <b>link community children's nurse</b> for each local GP practice or group of GP practices/network/hub.	Named CCN for network and job description	14,18, 21, 28, 42
26	<p><b>All healthcare organisations ensure planning for children is included in major incident plans and are involved routinely in appropriate major incident exercises.</b> Children may be involved in a significant incident or emergency, either as casualties or as members of families or groups caught up in the event. Plans need to reflect procedures for dealing with paediatric casualties arising either directly or indirectly from an incident. Counselling is available to children and families after any event and through monitoring for symptoms of trauma with appropriate support being offered where identified.</p>	Evidence in plans	44, 47, 48, 49, 50
27	<p><b>Bed numbers should meet the capacity for needs and should accommodate variable admission rates.</b> This equally applies to acute models of hospital at home or virtual ward for children.</p>	Capacity and demand analysis and bed occupancy rates monitored	20
28	There should be good access to diagnostics for acute hospital at home and virtual ward services.	Operational policy	20, 51
29	<p><b>Discharges can be nurse-led according to pre-set criteria</b> with robust safety netting and clear re-attendance policies. This equally applies to acute models of hospital at home or virtual ward for children.</p> <p>Discharge criteria to include communicating information on prescribed medicines to nominated community pharmacies to ensure continuity of supply and to support the pharmacist in the delivery of medicines reviews and other medicines optimisation services in pharmacies and other clinical settings.</p>	Agreed criteria within discharge policy Operational policy	14, 20, 31, 52, 53, 54
30	<p><b>It is essential to ensure that scopes of prescribing practice are reviewed regularly.</b> The service includes non-medical prescribers to prescribe medications for a child where appropriate. This standard equally applies to acute models of hospital at home or virtual ward for children.</p> <p>Formulary development should include children's requirements and not solely</p>	Non-medical prescribing policy or inclusion within medicines management policy Minutes from medicines management meetings	20, 55, 56

	focus on adults with long term conditions	Recruitment of pharmacist into clinical setting such as GP practices	
31	<p><b>Due to close working with children and families, Community Children's Services, which includes CCNs, paediatricians, AHPs and other related health professionals, are well placed to use every opportunity to maximise health and wellbeing and improving health outcomes through health promotion strategies</b> including:</p> <ul style="list-style-type: none"> <li>➤ Smoking cessation</li> <li>➤ Healthy eating and weight management (e.g. growth measurement, calculation of body mass index(BMI))</li> <li>➤ Alcohol misuse</li> <li>➤ Long term health needs</li> <li>➤ Substance misuse</li> <li>➤ Mental health or emotional health and psychological wellbeing concerns</li> <li>➤ Dental care</li> <li>➤ Sexual and reproductive health</li> <li>➤ Promoting engagement and participation in school, home and community occupations</li> </ul>	Audit of notes	14,39, 44, 57, 58
32	<p><b>Where appropriate there are opportunities for self-referral and clear lines of referral to specialist services as required</b></p> <p>Utilising community pharmacies to support self-care for children through public health campaigns and awareness of self-care using over the counter medicines. Supporting the development of referral pathways from pharmacies into specialist services</p>	Operational policy or patient information or public website	39, new pharmacy contract is awaited
33	<p><b>Developmentally appropriate and easy-to-understand information is available on a range of sexual health issues</b>, including contraception, emergency hormonal contraception, sexually transmitted infections (STIs), relationships, use of condoms and sexuality. The information makes it clear that prescriptions for contraception are free. Staff need to ensure that the young person understands the information. If the family or young person cannot read, other ways to provide information need to be identified e.g. use of translator or audio recordings.</p> <p>There is a sexuality policy in place to support both staff and young people, which are regularly reviewed. Staff need to provide support that is within the</p>	Portfolio of information available Operational policy	39, 59

	law and principles of safeguarding, and that complies with professional codes of conduct.		
34	<b>Using telehealth where this helps to reduce travelling for both families and service staff.</b> Effective use of telehealth to support clinicians in assessing and treating children and young people closer to home. Teleconference facility for multi-disciplinary meetings should be available.	Operational policy	14,60
35	There will be standards for Paediatric Oncology Shared Care Units (POSCUs) in relation to community children's teams (especially CCNs).	Operational policy	61
<b>B GOVERNANCE AND ACCOUNTABILITY</b>			
<p>Lord Darzi established a single definition of quality in his 2008 review <i>High Quality Care for All</i> (<a href="#">High Quality Care for All: NHS Next Stage Review Final Report, Department of Health, June 2008</a>). This definition is now enshrined in law through the <i>Health and Social Care Act 2012</i>, and comprises of three dimensions of quality, all of which are required for a high quality service:</p> <ul style="list-style-type: none"> <li>➤ Clinical effectiveness</li> <li>➤ Patient safety</li> <li>➤ Patient experience</li> </ul> <p><a href="https://www.gov.uk/government/publications/nhs-boards-guidance-on-quality-governance">https://www.gov.uk/government/publications/nhs-boards-guidance-on-quality-governance</a></p> <p>Services should offer value for money, be clinically effective and equitable. Services should be commissioned over a realistic time frame to allow development of new services and the sustainability of established services. Services should then work within the available resources taking account of economic, social, political and environmental factors <sup>15</sup></p>			
	<i>Standard</i>	<i>Evidence</i>	<i>Ref</i>
36	All organisations and services providing out-of-hospital care must: <ul style="list-style-type: none"> <li>➤ Have an operational policy</li> <li>➤ Have an organisational chart of the structure</li> <li>➤ Ensure that services are compliant with statutory standards for Looked After Children (LAC)</li> <li>➤ Meet Care Quality Commission (CQC) key lines of enquiry (KLOE) standards (refer to CQC community health services provider handbook)</li> </ul>	Operational policy Organisational chart Evidence of audit and compliance against standards (LAC) Evidence of audit and compliance against KLOE	62

		standards Demonstrated in published plans, reports and in management structure to support the service	
37	All organisations must deliver care according to the RCPCH guidelines and standards for child health.	Evidence of audit and compliance against standards	63
38	All staff working in facilities where children present are trained in paediatric basic life support. They should have the appropriate equipment to manage paediatric emergencies until emergency services arrive.	Operational policy for paediatric service	44, 47, 64
39	<b>There are documented, regular meetings attended by senior healthcare professionals</b> from hospital, community and primary care services and representatives of children and their parents and carers to monitor, review and improve the effectiveness of out-of-hospital and local unscheduled care services. There is a programme of audit across all elements of the service. All services that manage children are aware of, submitting data to and participating in appropriate national, regional and local clinical audit programmes.	Evidenced by minutes Submission of data to national audit programmes	15, 21, 40, 44, 47, 65, 66, 67, 68, 69, 70
40	There should be clear information sharing arrangements across hospital, community and primary care. For example, a child shared electronic healthcare record.	Evidenced by guidance	19, 21
41	All providers must participate in child death overview panel (CDOP) process as required. Audits/clinical reviews of all child deaths.	Evidence of policy, process and checklist in place	44, 47, 71
42	<b>All deaths are discussed and recorded at a morbidity and mortality meeting.</b> A “Rapid Response Team (RRT)”: A group of key professionals who come together for the purpose of enquiring into and evaluating the cause of death where the death of a child is “unexpected”. A Child Death Overview Panel: The panel is responsible for reviewing information on all child deaths (“expected” and “unexpected” under the age of 18 years) and is accountable to the Local Safeguarding Children Board. An England wide review of safeguarding arrangements and CDOPs has been completed. <sup>72,73</sup> Following the Mazar's review into Southern Health NHS Trust there are a number of recommendations for mental health and learning disabilities services which	Evidence of participation in CDOP panels from minutes of meetings and attendance lists	15, 72, 73, 74, 75

equally apply to community health services.

## C WORKFORCE PLANNING, EDUCATION AND TRAINING

Services should be able to provide evidence of their workforce strategy and planning around new roles (e.g. physician's associates, nursing associate role and therapy assistants), skill mix and engaging with the local community working age population. Workforce plans need to include retention of staff and career development.

The *Facing the Future* standards have workforce implications for three principal staffing groups: children's nurses, paediatricians and GPs. There are also workforce implications for other staffing groups including AHPs and the pharmacy workforce, administration and support staff and managerial support.<sup>76</sup>

There is a body of evidence supporting the standards expected of nurses and paediatricians working in out-of-hospital health services; many are directly translatable to AHPs and community pharmacists.

There is evaluated and high quality training for all professionals/agencies as appropriate to the population they serve. This should be seen as driven by inter professional opportunities for learning. As minimum competencies this should include training around safeguarding, resuscitation, communication, child development and acute assessment.

Opportunities to support trainees/students in out of hospital settings are central to workforce planning.

	<i>Standard</i>	<i>Evidence</i>	<i>Ref</i>
43	There is a single organisational structure delivering a comprehensive CCN service led by registered community children's nurses, supported by assistant practitioners, support workers and with administrative support. This applies to community children's services workforce.	Organisational structure	14, 19, 20
44	To ensure organisations can deliver the eleven standards within <i>Facing the Future Together for Child Health</i> they should be reflected within workforce planning and modelling.	Workforce strategy	21
45	There should be evidence of dialogue between provider clinicians and commissioners around new ways of working and this should include evidence of what competencies would be required.	Minutes of meeting Competency checklist	77

46	Where unscheduled urgent care is delivered at home for acutely sick children (Hospital@Home /virtual ward), the DGH general acute paediatric rotas are applicable (made up of at least ten whole time equivalents, all of whom are European Working Time Directive compliant)	Operational policy Evidenced through rotas	36, 44
47	The role of the health care assistant (HCA) and support worker is evident in roles supporting children and young people in a variety of community settings including nurseries, schools, community pharmacies and continuing care (care is often delegated by a registered nurse). Training of pharmacy support staff in the signposting of CYP to support services especially in evening and weekend scenarios when pharmacies are open and accessible to the public	Operational policy of CCN team	14, 89
48	The service includes non-medical prescribers and pharmacists in other clinical settings to prescribe medications for a child where appropriate.	Operational policy	14, 19, 20, 43, 56
49	Community Children's Service and the CCN team have the following attributes <ul style="list-style-type: none"> <li>➤ A sustainable service with robust workforce planning and development and the innovative use of critical mass of workforce within a locality</li> <li>➤ Staff with the right skills will be available in the right place at the right time</li> <li>➤ Providers and commissioners of health care services must undertake robust children's services workforce planning</li> <li>➤ Local recommendations for staffing levels for Trust children's nursing services based on the recommendations of the Royal College of Nursing (RCN)(2013) <i>Defining staffing levels for children and young people's services</i> will be developed</li> <li>➤ For an average-sized district, with a child population of 50,000, a minimum of 20 whole time equivalent (WTE) community children's nurses are required to provide a comprehensive CCN service in addition to any individual child-specific continuing care investment (RCN, 2009a; 2009b) and does not include the wider paediatric and AHPs' workforce</li> </ul>	Operational policy Rotas and skill mix	14, 43, 89
50	<b>The community children's service should recognise the guidance <i>RCN children and young people's nursing: a philosophy of care</i> (RCN, 2014).</b> The community children's workforce (nurses and AHPs) should be competent and skilled in caring for children and young people and should be able to engage and communicate with them to enable and ensure service users are able to participate in decisions about care and services and put them and their	Operational policy	60, 78, 79, 80, 89

	parents/carers at ease. There are a number of standards for District Nurses, which are applicable to CCNs, for example evidence of the level of education and training of staff working outside hospitals. This includes specialist and advanced nursing.		
51	<b>The team has the knowledge, expertise and capability to lead and co-ordinate</b> the delivery of services to children in the community, which are flexible and personalised to meet identified health and well-being needs and are not restricted by diagnosis. CCNs and community AHPs should have competencies covering a breadth of clinical skills and their role encompasses assessment, education, training, emotional support and expert clinical care and requires high order cognitive skills in relation to decision-making, problem solving and solution finding to support the holistic needs of the child and family.	Operational policy	14, 19, 20, 89
52	Learning disability staff with specific child health knowledge and skills also play a central role in the lives of children and young people with learning disabilities, within a needs-led skill blended community children's service and CCN teams.	Organisational structure	14,89
53	All staff looking after children to be trained in acute assessment of the unwell child, pain management and communication, mental health assessment and first aid, and have appropriate skills for resuscitation and safeguarding. Training to be updated on an annual basis or as appropriate.	Evidence of training in spotting the sick child	40, 44
54	Services should be delivered by clinicians and non-qualified staff who have the appropriate competencies and are regularly appraised to ensure they maintain their skills and fulfil continuing professional development (CPD) requirements as determined by their professional regulators.	Evidence of study days and attendance lists	15, 26, 81
55	Appropriate appraisal, supervision and support are offered to staff.	Evidence of appraisal system in place	19, 39, 43
56	There should be on-going support and training for school nurses and AHPs who are working with CYPs with long term conditions (LTCs). This should be extended to the school staff as appropriate.	Operational policy	15
57	Members of staff routinely receive inter-disciplinary training on the issues of confidentiality and consent and issues pertaining to seeing young people without a parent/carer present. There is adequate capacity for inter-disciplinary learning in line with local Safeguarding Children arrangements to ensure that approaches to safeguarding are in line with <i>Working Together to Safeguard Children</i> .	Operational policy Training presentations and materials on confidentiality issues provided	4, 19, 39, 85
58	Each acute general children's service provides, as a minimum, six-monthly	Evidence of training sessions	21, 46

	education and knowledge exchange sessions with GPs and other healthcare professionals who work with children with unscheduled care needs.	and attendance	
59	The training needs of primary care (GPs, practice nurses, AHPs, community pharmacists and pharmacy support staff) services in relation to paediatrics and young people should be reviewed and a training programme set up to meet those needs. Community pharmacists and other primary healthcare professionals should have equity of access and support in training.	Evidence of training needs assessment and programme Inclusion of community pharmacies in capacity planning and design of training needs assessment and programmes	43
60	<b>All staff receive training, supervision and relevant (commensurate with their role) appraisal to ensure that they are competent to:</b> <ul style="list-style-type: none"> <li>➤ Discuss necessary and relevant health issues with young people and understand the health needs of young people in the context of people's lives and relationships</li> <li>➤ Work with parents/carers/family and friends where appropriate in culturally appropriate ways</li> <li>➤ Make appropriate referrals when necessary</li> <li>➤ Manage sensitive and/or difficult consultations.</li> <li>➤ Support young people in making their own informed choices</li> </ul> All staff receive training on: <ul style="list-style-type: none"> <li>➤ Understanding, engaging and communicating with young people promoting attitudes and values</li> <li>➤ Equality and human rights issues</li> <li>➤ Spotting the sick child (refer to <a href="http://www.spottingthesickchild.com">www.spottingthesickchild.com</a>)</li> </ul>	Evidence of training programme	39, 108
61	GPs and consultants regularly share knowledge to enhance skills. GPs need to be clear about their child health knowledge and gaps, and regularly take up opportunities for CPD in this area and evidence towards revalidation/appraisal	Evidence of GP CPD in CYP	18, 60
62	Bands 1-4 require a care certificate	Evidence of training programme for the care certificate for CYP	44, 79, 82, 83
63	All healthcare professionals who work with children and their parents and carers should undertake the validated 20 minute online training from the National Centre for Smoking Cessation Training on <a href="#">Very Brief Advice</a> or an equivalent evidence-based programme.	Training provision and number of staff who have undertaken the training	84, 126
64	All staff working in facilities where children are seen are trained in paediatric	Evidence of staff trained in	44, 47

	basic life support.	Advanced paediatric life support (APLS)/ European paediatric life support (EPLS) depending on the service need	
	<b>D PATIENT AND FAMILY SUPPORT, INFORMATION PROVISION AND EXPERIENCE</b>		
	<p>This includes the experience of the child and family accessing the service, and also how they are involved in the assessment, running and development of any future service. Information governance arrangements need to be clearly in place and applicable to children. Children who are deemed Fraser competent (<a href="https://www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/gillick-competency-fraser-guidelines/">https://www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/gillick-competency-fraser-guidelines/</a>) should have the ability to refuse parents/carers access to all or part of their online notes. Standards 65-68 relate to specifications detailed within the DH <i>You're Welcome</i> standards and relate specifically to young people. Good practice would apply the standards to children of all ages.</p>		
	<i>Standard</i>	<i>Evidence</i>	<i>Ref</i>
65	<p><b>The service provides information in variety of languages and formats including leaflets for young people</b> explaining:</p> <ul style="list-style-type: none"> <li>➤ What the service offers</li> <li>➤ How to access the service</li> <li>➤ What will happen when they access the service</li> <li>➤ How the service is linked to other services</li> <li>➤ The content and style of the leaflets is appropriate for young people</li> <li>➤ How to access other services and get appropriate onward referral</li> <li>➤ How to make comments, compliments or complaints about the service</li> <li>➤ Who else has access to any information that the young person shares with the service</li> <li>➤ Circumstances under which information may be disclosed or shared</li> <li>➤ Service publicity material is available in the languages that are used by the local community of CYP, as appropriate and if possible, and digital media are used e.g. webpage, twitter</li> </ul> <p>All information provided by the service is kept accurate and up-to-date. In accordance with the Equality Act 2010:</p> <ul style="list-style-type: none"> <li>➤ Service publicity material is available in forms that can be easily understood by young people with learning disabilities</li> </ul>	Portfolio of available information Available support documentation	39

	<ul style="list-style-type: none"> <li>➤ The service will provide information for people with physical disabilities or sensory impairments in an appropriate format</li> </ul>		
66	<p><b>The service provides young people, their parents and carers with:</b></p> <ul style="list-style-type: none"> <li>➤ Advice and information to help informed decision-making including choices. Discussions take place at the beginning and throughout therapeutic contact</li> <li>➤ Information materials to help informed decision making</li> <li>➤ Information and advice to help young people and their families to make decisions regarding their psychological wellbeing and mental health support needs, and treatment choices based on informed consent. The service makes routine attempts to offer flexibility about involving other professionals in the assessment and treatment process. The service explains the roles of staff they might encounter</li> <li>➤ All methods of communication and information-sharing are confidential</li> <li>➤ The cultural needs of children or young people and families are respected</li> </ul>	<p>Portfolio of available information Evidence of joint care planning across agencies e.g. Education, Health and Care Plans (EHCP) for SEND</p>	39
67	<p><b>The family should feel that they have been listened to and heard</b> and that their comments have been acknowledged. All health organisations must demonstrate how they have listened to the voice of children and young people, and how this will improve their health outcomes and is person centred.</p>	<p>Patient engagement policy Patient engagement survey Evidence of children engagement in service improvements and developments</p>	39, 43, 45, 85
68	<p><b>Services are flexible about involving other people in the assessment and treatment process, particularly at first contact, and:</b></p> <ul style="list-style-type: none"> <li>➤ Young people are offered appropriate information and advice to help them understand what can be achieved without parental or family involvement wherever this is considered to be therapeutically beneficial. Refusal of consent to family involvement is accepted unless there is serious risk to the young person's welfare</li> <li>➤ Even when assertive action is needed, there is some flexibility about what choices can be made available and which treatment the young person would like to receive. Even in cases where the overriding serious risks lead to compulsory treatment, young people should always be offered appropriate information and advice to make treatment choices</li> </ul>	<p>Operational policy Patient experience measures are in place/feedback regularly audited and fed back</p>	39

	based on informed consent		
69	<p><b>Children, young people and their families, as experts of experience, should be consulted in relation to current services and throughout service planning and development and be at the heart of decision-making about their own/their child's health.</b> The child or young person and his or her family have been involved in the design of the care pathway. Processes are in place to ensure that young people's views are included in governance service design and development. Young people are routinely involved in reviewing local service provision against the DH's <i>Quality criteria for young people friendly health service</i> to ensure the service meets their needs; these are reviewed and acted on as appropriate. The service carries out regular surveys of user experience of services to ensure that they have a positive experience of care, including</p> <ul style="list-style-type: none"> <li>➤ Carers</li> <li>➤ Children</li> <li>➤ Service users' perception of care coordination</li> <li>➤ NHS Friends and Family Test</li> </ul>	<p>Minutes demonstrating patient involvement in decisions about service development  Patient experience measures in place/feedback regularly audited and fed back  Evidence that complaints are used to improve services  Evidence of involvement in relevant consultations  Reporting and action plans</p>	18, 24, 39, 42, 86
70	<p><b>All clinicians involved in care for 0-18 year olds are familiar with current legislation around consent, competency, confidentiality, mental capacity and safeguarding data protection, human rights and Children Act 2004.</b> Also awareness of the <i>Mental Capacity Act</i> at time of transition to adult services (also during the period of transition).</p>	<p>Evidence of training available for staff  Policy and consent to treatment processes in place  Case notes audit  Examples of information for children and parents  Results from feedback surveys of parents and carers  Accessibility of relevant materials</p>	4,15, 39, 41, 44, 47, 49, 69
71	<p>There is a standard operating procedure or process on confidentiality and consent, consistent with current DH guidance.</p>	<p>Evidence of training available for staff  Policy and consent to treatment processes in place  Case notes audit  Examples of information for children and parents</p>	15, 36, 39, 40, 41, 44, 69

		Results from feedback surveys of parents and carers Accessibility of relevant materials	
72	There are electronic discharge summaries for GPs and other health professionals within 24 hours, shared with CYP and their families where there is acute hospital at home. These should be available 7 days a week.	Audit of discharge summary times	19, 21, 24, 36, 40,44,47,49,60, 69, 87, 88, 126
73	If the child takes any medication, the parent should know what, why, for how long and how much. For example children with complex health needs should have a medication card/passport to summarise complex drug therapy or multiple therapy.	Patient information accessibility	45
74	It is best practice to provide personalised care and the opportunity to see familiar faces, not different health professionals every time. This includes continuity of care from the same AHP where possible.	Patient experience survey to include CYP, parents and carers and the family's views that they have the right people involved in the CYP's care	60
75	The process of giving prognostic and diagnostic information should follow established guidelines, whichever professional undertakes the task. Where necessary training should be provided.	Evidence of policy and guidelines Audit of staff training and knowledge	45
<b>E CONNECTION AND CARE COORDINATION</b>			
<p>Connection and coordinated care improves continuity, reduces fragmentation within the health and social care systems and delivers good patient outcomes. Collaboration between local authorities, commissioners, services providers and frontline staff has been instrumental in delivering successful integrated /connected care models.</p> <p>A whole system approach is needed to effectively shift health care out of hospitals, where possible and safe to do so, and provide new services in the community. Healthcare professionals play a pivotal role in supporting and promoting better co-ordinated care.<sup>89</sup></p> <p>Investments must be made to strengthen the entire out-of-hospital/community workforce and priority must be placed on enabling and supporting staff through education, training and developing leadership skills to ensure the right nurses and AHPs with the right skills are leading the way.<sup>89</sup></p>			

	Pathways of care should be agreed and owned by all stakeholders, including children and families, explicit and clearly written so that access to services is transparent. There should be networking between primary, secondary and tertiary care, facilitating access to specialists' assessment and intervention when appropriate, and providing shared care locally. There should be liaison with local and national voluntary organisations. <sup>15, 51</sup>		
	<i>Standard</i>	<i>Evidence</i>	<i>Ref</i>
76	<p><b>Ideally relevant services for children and young people are co-located to maximise connection, collaboration and integration.</b> Services should consider aspects of vertical, horizontal, longitudinal and population integration for decisions about co-located services.</p> <p>Where this is not the case, the following criteria are met:</p> <ul style="list-style-type: none"> <li>➤ Service provides information about other local services for children and young people</li> <li>➤ All staff are familiar with local service provision and arrangements for referral</li> </ul> <p>Information about the service is provided to other relevant organisations and to key professionals working with young people, for example having a comprehensive directory of services.</p>	Evidence of patient and professionals information provided Directory of services or similar	14 ,39, 90
77	<p><b>There is an overall named professional for the handover system and coordination of the care of the child or young person.</b> See appendix 2 for details of this role. Information-sharing processes are in place</p>	Job description	18, 42
78	<p><b>Primary, secondary, tertiary and community services should work closely together</b> and meet regularly to review clinical practice, share best practice initiatives and ensure joined up care, including when children move into adult services. This should also include school nursing teams and education colleagues to facilitate the child's access to education.</p>	Minutes of network or system meeting	14, 42, 43, 60, 65
79	There should be integrated care for each child or young person with a long term condition or complex disability. The child should have an EHCP plan which is comprehensive and all inclusive.	Audit of clinical records	14, 19, 43, 85
80	GP Practices should identify children (e.g. those with long term conditions) who would benefit from coordinated care and continuity and should proactively review those that are identified on a regular basis. Such patients should have a named professional who oversees their care and ensures continuity.	Job description Audit of care plan	37, 91

81	There should be out-reach paediatric outpatient services and closer connection of acute trust paediatric services (medical, AHPs and nursing) and community children's services.	Operational policy	43
82	Each child identified for coordinated care (e.g. with a long term condition) should be invited to participate in a holistic care planning process in order to develop a single care plan that can be shared with teams and professionals involved in their care.	Operational policy Evidence of a single care plan, for example the EHCP plan	37, 47
<b>F TRANSITIONAL CARE</b>			
<p>Children's service models of working are often very different from those of adult services. Children's services generally focus on the health needs of the child and family, whilst adult health services are organised around clinical systems e.g. respiratory, gastroenterology and neurology. So moving from one service to the other can be a very daunting prospect for young people. Therefore, transition is presented as a key topic in this document.</p> <p>Transition to adult services should be as seamless as possible. It should commence from age 14 onwards and last until 25 depending on the complexity/disability of the young person. The personalisation of care should be clear during transition. It requires careful planning and collaborative working between the child/young person, adolescent services and adult services. The process of transition is expected to take longer where a child has multiple, complex needs, but the key feature of transition is that care should remain flexible at all times.</p> <p>The updated <i>NICE guidance</i> (2016) focuses on transition support<sup>92</sup>. This should be developmentally appropriate, taking into account the person's: maturity, cognitive abilities, psychological status, needs in respect of long-term conditions, social and personal circumstances, caring responsibilities and communication needs. Transition support should be strengths-based and focused on what is positive and possible for the young person rather than on a pre-determined set of transition options, identifies the support available to the young person, which includes but is not limited to their family or carers</p> <p>Service staff are aware of, and make a conscious effort to improve, the resilience factors, which support good health in young people – for example, parental involvement, and empowering young people. Services should consider the possibility of adopting a mentoring scheme where a young person who has already undergone the transition may be able to offer help and support to other new arrivals.</p>			

	<i>Standard</i>	<i>Evidence</i>	<i>Ref</i>
83	There are nine overarching principles in the <i>NICE guidance</i> , which organisations should comply with. See Appendix 3 for the pathway and overarching principles.	Compliance with NICE guidance	92
84	Organisations should monitor how safely children and young people transition, identifying any gaps in service and compliance with NICE principles.	Risk register NICE action plans	19, 43, 92
85	<b>Local services must work together, along with the young people and their families, to plan the transition.</b> An example; for a young person moving from CAMHS to adult mental health services and hospital services, a comprehensive written summary of the CAMHS notes is available to the receiving service, with appropriate consent for the receiving service to help provide an overview of past mental health issues. Staff in both services are aware of the anxiety that the transition may create for young people and parents, and that sometimes young people's mental health may suffer as a result. The service ensures that the emotional, physical, psychological and spiritual needs of young people are met.	Operational policy Referral pathway	14, 39, 93, 100
86	<b>Service providers should examine the way transition services are delivered.</b> Services may need to be redesigned so that they truly meet the needs of young people rather than the needs of the service. Co-production and co-design are successful models of engaging young people to manage their long-term conditions such as sickle cell disease. In order to reduce missed appointments, improve adherence to therapeutic regimes and so that young adults are engaged and involved in their own treatment, services should be accessible, flexible and acceptable to these patients. For example, drop-in clinics and online information can make a service more accessible and approachable.	Evidence of co-production and co-design of services	74, 94, 95, 100
87	<b>For children who have transitioned into adult services, healthcare professionals need to be aware that parents or carers will have varying degrees of contact with, and responsibility for, the young person.</b> It is important for coordinators of care to understand this level of contact and also to agree appropriate communication channels in collaboration with the parents /carers and the young person. These discussions must include issues of confidentiality	Evidence of training	100
88	<b>All professionals and voluntary organisations are aware of each other's role in transition and the services offered.</b> In planning to meet an individual's needs, NHS and social services providers should not overlook the services	Operational policy	19, 96, 100

	available locally from the voluntary sector and on-going connection for education advice and health education.		
89	<b>Appropriate staff members are trained to help young people, and their parents or carers, with the transition to adult services from the age of 14 onwards.</b> Transition is properly planned and all young people with on-going needs have an individual transition plan. The timing and duration of transition is negotiated with the young person and agreed by all relevant parties. A named coordinator of care is appointed for each child (and family) and must collaborate with other professionals and provide continuity during the transition process. The young person is involved in the planning and delivery of their own care. A transition plan should include an assessment of their knowledge and skills and an intervention to help them to self-manage.	Operational policy Audit of effectiveness Named key worker and job description Evidence of child/parent involved in care plan	44, 46, 47, 100, 97, 98, 99, 126
90	<b>Care is handed over in a planned and collaborative way, through meetings between at least one key professional from both services and the young person</b> (and their parents/carers if appropriate). If possible, the young person should have the opportunity to visit the clinical environment in advance or meet the team who will take on their care. The young person understands how and when therapeutic contact will come to an end in one service, and agrees this with transition coordinators of care.	Operational policy	45, 100, 123
91	<b>Transition is included in education and training programmes for both adult services and children and young people’s services.</b> All staff working with young people and young adults to receive specific training about their needs.	Training materials available	46, 100
92	All services use a variety of ways to access the service, and venues which suit young people.	Patient experience survey Analysis of “did not attend”(DNA)	100
93	The service provides publicity material specifically outlining the transition to adult services. This material is presented in a way that is young people friendly.	Portfolio of material	39
94	The child’s future needs (for example, for care in adolescence and adult life, or for palliative care in the case of progressive disease) should be discussed with the parents and child as soon as possible.	Operational policy	45

## G PALLIATIVE CARE

A comprehensive local Children's Palliative Care (CPC) service spans health, social care and education. It is a whole-family approach and is flexible and focused on children, their parents and their siblings. CCGs also need to be aware of their duties under the *Children and Families Act 2014*<sup>8</sup> relating to palliative care. There is reference to the standards of care provided within *Together for Short Lives*<sup>101</sup>, which provides a comprehensive picture. The NICE draft guidance on children's end of life care<sup>102</sup> is out for consultation and once approved the standards will need to be implemented.

	<i>Standard</i>	<i>Evidence</i>	<i>Ref</i>
95	<p><b>The CPC service:</b></p> <ul style="list-style-type: none"> <li>➤ Is accessible 24 hours a day, seven days a week, 365 days a year – from diagnosis or recognition to bereavement</li> <li>➤ Supports and enables children and families to choose the type, location and the provider of the care they receive and allows them to change their mind. It is not age, time or diagnosis specific – 15% of children who need CPC have no definitive underlying diagnosis</li> <li>➤ Is multi-disciplinary and multi-agency</li> <li>➤ Is accessible to people of different faiths, culture, ethnicity and locations</li> <li>➤ Includes pre and post-bereavement support for families</li> <li>➤ Is able to manage symptoms</li> <li>➤ Supports parents in caring for their children according to their needs and wishes</li> <li>➤ Supports and enables smooth transitions for young people with life limiting and life threatening conditions who move from children's to adult's services</li> </ul>	Operational policy Patient and family experience surveys	46, 105
96	<p><b>There should be a locally available and community driven CPC</b> which is supported by:</p> <ul style="list-style-type: none"> <li>➤ Specialist medical input (e.g. paediatricians/children's palliative care consultants with expertise in the child's condition)</li> <li>➤ Sustainable community children's nursing teams and AHPs</li> <li>➤ Children's hospice services</li> <li>➤ Specialist palliative care providers</li> </ul>	Operational policy	14, 31, 32, 55, 105

	<ul style="list-style-type: none"> <li>➤ Access to secondary and tertiary care</li> <li>➤ Emotional and psychological support</li> <li>➤ Local authority children's services – social care (including services providing equipment to disabled children), education, housing and leisure</li> <li>➤ Community paediatrics</li> <li>➤ Primary care</li> </ul> <p>There should be timely access to medicines in palliative care formularies in local community pharmacy networks and access to a pharmacist for advice on the safe use of palliative care medicines especially in OOH scenarios.</p>		
97	<p><b>All children and young people with palliative care needs should be identified</b> as this will allow CPC networks to plan appropriate services and to analyse the gaps between existing provision. The CPC specialist team should contribute expert advice to this process.</p>	Organisations' strategic annual plans	103
98	<p><b>Children who need CPC require holistic support which is currently arranged through health, social care and education.</b> CCGs should consider commissioning CPC in partnership with local authorities using agreements under section 75 of the <i>National Health Services Act 2006/7</i> to ensure an integrated service for children with life-limiting and life-threatening conditions. The Government's new <i>Children and Families Act (SEND)</i> for 0 to 25 years states that local offers should include information about palliative care for children with complex health needs. CCGs should also consider working in partnership with CPC networks and providers in the statutory and voluntary sectors, including children's hospices.</p>	Operational policy	104, 105
99	<p><b>Every child and young person should receive a multi-agency assessment of their palliative care needs</b> and have an emergency healthcare plan, including a personal resuscitation plan as indicated, agreed with them and which identifies a lead professional/key worker for the family and provides co-ordinated care and support to meet these needs.</p>	Evidence of multi-agency assessments and plans	103
100	<p><b>Each child or young person with palliative care needs should have a co-ordinated package of care including a quality assessment;</b> access to key working and appropriate equipment; and measurement of the individual's and their family's experience of the service. This should include symptom management.</p>	Operational policy	103

101	<b>Every child and young person should have an identified lead paediatric consultant</b> who will work with the CPC Team and GP. The child's lead paediatric consultant (this consultant may be the specialist CPC consultant) will have overall clinical responsibility for ensuring that care is coordinated in a holistic manner.	Job descriptions	103, 122
102	The Core Care Pathway has been developed as a tool for professionals who support children with life-limiting and life-threatening conditions and their families throughout their care journey, from diagnosis through to end of life care and bereavement support. It provides a clear framework for all practitioners and aims to facilitate a care process, supported by good communication between professionals across all care settings. It places the child and family at the centre of the planning process, and provides practical guidance at key stages of a child's care journey.	Operational policy and use of the pathway	105
103	Every child, young person and family should be supported to agree an end of life plan when the end of life stage is recognised. This should include choice of place of care, place of death and completion of an emergency healthcare plan including personal resuscitation plan as indicated. The NICE draft guidance on children's end of life care is out for consultation and once approved the standards will need to be implemented.	Evidence of end of life plans Assessment against new NICE guidance once approved	102, 103
104	When treating children, the service will additionally follow the standards and criteria outlined in the <i>Specification for Children's Services</i>	Operational policy	103
	<h2>H ACUTELY SICK CHILD</h2> <p>Implementation of the <i>Five Year Forward View</i><sup>11</sup>, <i>Transforming Primary Care in London: A Strategic Commissioning Framework</i><sup>37</sup> and <i>Children and young people's health services in London- A Case for Change</i><sup>106</sup> will lead to significant transformation in the way that primary care and acute non-hospital services are delivered for children and young people across the capital. These documents combine to set out a vision for new models of care and service delivery. They describe fundamental changes to the range, consistency and quality of services available to all patients, with a drive to care for them in a non-hospital setting.</p>		
	<p>Examples of new models of care include helping children and young people recover from ill health or following injury by reducing admissions and preventing serious illness of children with lower respiratory tract infections through the use of urgent care pathways and advanced nurse practitioner roles. This supports the high volume conditions not requiring hospitalisation (ambulatory sensitive</p>		

	conditions) and enables follow-up care closer to home and including delivery and support in education settings. <sup>86</sup>		
	HLP is undertaking a process of financial modelling to gain more of an understanding of the financial impact of new acute models of care for CYP. Commissioners and providers will receive the output from this work and any subsequent recommendations.		
	<i>Standard</i>	<i>Evidence</i>	<i>Ref</i>
105	Acute general children's services should work together with local primary care and community services to develop care pathways for common acute conditions with the appropriate escalation and referral pathways.	Evidence of care pathways with escalation pathways	14, 21, 88,107
106	Children with urgent or emergency needs will need to undergo a rapid assessment. All GPs should have systems in place with skilled staff that are confident and competent to recognise a sick child, to ensure these patients are effectively identified and responded to appropriately. All GP practices should ensure compliance with the NICE pathway for fever in children and sepsis.	Local policies and protocols in GP practice Audit and compliance against NICE pathway and UK Sepsis trust clinical toolkit	37, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117
107	All children who are cared for by hospital at home teams or paediatric assessment units (PAU) should have clear and robust pathways in place for investigations, activity and transfers (to an in-patient facility or discharge to OOH care). There should be timely access to therapies. Medicines optimisation is in place through local community pharmacy networks with access to advice.	Evidence of pathways	31, 32, 43
108	Nursing staff and AHPs are able to assess a child's symptoms, recognise an unwell child and take the first steps in the management of the child's condition, including referring to an appropriate professional. For example, <a href="http://www.spottingthesickchild.com">www.spottingthesickchild.com</a>	Audit and compliance against standards	19, 20, 108
109	There is an accessible, adequately staffed and resourced acute pain service that covers the needs of children. This needs to provide advice for community providers as well as hospital services.	Operational policy	39, 44, 70, 118
110	For children with learning disabilities and/or challenging behaviour who become acutely unwell, there need to be systems in place to ensure early communication between the hospital and community health and education providers.	Operational policy	109, 119
111	There should be arrangements for children with complex health needs, including learning disabilities, to be seen urgently on request. The family should know whom to contact in the event of new problems. For example using passports / family held health records.	Operational policy	45
112	The child should receive regular appropriate follow ups in the right place based	Evidence of audit of follow ups	31, 45, 52, 53

	on their health needs including medication reviews.		
	<b>I LONG TERM CONDITIONS</b>		
	NHS providers should be supporting children with long term conditions (e.g. asthma, diabetes or epilepsy) to be as independent and healthy as possible and minimise complications and exacerbations requiring unscheduled admissions to hospital. If they do need to be treated in hospital, the providers should work with social care and other services to ensure that children are supported to leave hospital and recover at home. <sup>120</sup>		
	<i>Standard</i>	<i>Evidence</i>	<i>Ref</i>
113	Local co-ordinated pathways across primary, secondary and tertiary care should be developed and implemented for common childhood illnesses and long term conditions and there should be access to psychological support and CAMHS.	Evidence of pathways	15, 18, 21, 43, 96, 97, 111, 121, 122, 123, 126
114	All providers of services for children should comply with all best practice tariffs (e.g. diabetes) and children's standards (e.g. epilepsy and London asthma standards).	Audit and compliance against standards	44,124, 125,126, 127
115	The community children's service and families should have access to specialist knowledge and advice for children with learning disabilities, those with common long term conditions, as well as epilepsy, enuresis, encopresis, mental health and tube feeding.	Rotas	14,15, 19, 85
116	There should be an annual health check for children with learning disabilities from age 14-25.	Audit	128, 129
117	Everyone with a LTC should have a care plan (or passport as appropriate) for school based support with step up/step down management. This should be coordinated with EHCP where appropriate. An example of this is the Epilepsy Passport, which contains essential up-to-date information about a child or young person's epilepsy, including their emergency care plan, medication history and key professional contacts. There should be access to appropriate services and seamless and timely admission and discharge. Care plans should identify difficult to sources medicines in community pharmacies either due to their cost, formulation or availability. Co-ordinated supply of medication between acute settings and community pharmacies should be regularly reviewed.	Audit	15, 44, 127, 130

## J SAFEGUARDING CHILDREN AND YOUNG PEOPLE

All staff working with babies, children and young people must be trained in the safeguarding of CYP and be competent and confident to access appropriate support and advice. All staff involved in the care of CYP must comply with the standards within London child protection procedures, including the [London Child Sexual Exploitation \(CSE\) Operating Protocol](#)<sup>131</sup>. Particular attention should be made to ensure that looked after children and young offenders are identified.

	<i>Standard</i>	<i>Evidence</i>	<i>Ref</i>
118	<p><b>Healthcare systems and processes, policies and procedures are in place to support healthcare professionals' practice in safeguarding children:</b></p> <ul style="list-style-type: none"> <li>➤ Safeguarding children policies and procedures are in place and available organisation-wide</li> <li>➤ Policies include how to raise concerns about work colleagues</li> <li>➤ A designated or named nurse and doctor for safeguarding children are appointed, whose contact details are known throughout the organisation and whose role and responsibilities are clearly outlined</li> <li>➤ A single, integrated child health record system, including mechanisms for obtaining records of previous attendances / admissions from other organisations, is in place to prevent miscommunication and gaps in shared information</li> <li>➤ All children's nurses and AHPs who come into contact with children and young people have undertaken initial training and annual updating in safeguarding children, commensurate with the professional's position and level of responsibilities</li> <li>➤ All those involved in child protection work have access to supervision and support from managers on a frequent and regular basis</li> </ul>	<p>Operational policy Safeguarding training programmes Evidence of named safeguarding doctor and nurse Evidence of policy and protocols available which states name and contact for designated leads and staff know how to raise concerns Evidence of single record in use or plans for working towards it Evidence of training and CPD Evidence of access to supervision for staff</p>	36, 39, 40, 44, 47, 68, 69, 70, 132
119	<p><b>All children and young people, children's social care, police and health teams have access to a paediatrician with child protection experience and skills</b> (with at least Level 3 safeguarding competencies) available to provide immediate advice and subsequent assessment, if necessary, for children and young people under 18 years of age where there are child protection concerns. The requirement is for advice, clinical assessment and the timely provision of an</p>	<p>Operational policy Evidenced by job plans and audit or written records</p>	36, 40, 44

	appropriate medical opinion, supported with a written report.		
120	Systems are in place to identify children and young people who attend frequently or who are not brought to follow up and have potential safeguarding concerns.	Not brought policy Protocol in place- audit of number of children triggering alerts	44, 47, 88
121	Access to urgent medical assessments and advice on health concerns for children who may have been abused must be in place as well as initial health assessments of children taken into the care of the local authority and the health component of statutory assessments of educational special needs.	Audit National reporting of key performance indicators (KPIs)	26
122	Appropriate health professionals attendance and participation in multi-agency child protection strategy discussions/conferences and other meetings.	Evidence of meetings	15
<b>K DISCHARGE AND CARE PLANNING</b>			
There should be clear pathways for discharge and care planning from admission to service back to primary care.			
	<i>Standard</i>	<i>Evidence</i>	<i>Ref</i>
123	Community children's teams should be part of the acute services discharge planning process for those children requiring integrated/connected care.	Operational policy	43
124	When a child presents with unscheduled care needs the discharge summary is sent electronically to their GP and other relevant healthcare professionals within 24 hours and the information is given to the child and their parents and carers. Access to medication in primary care should be considered and nominated community pharmacies used by the child's family should be included in the circulation of the discharge summary to ensure access to medicines and advice on taking medicines is available from a pharmacist especially in OOH scenarios.	Audit of discharge planning and timelines	19, 21, 24, 31, 36, 40, 44, 47, 49, 60, 69, 87, 88, 126
<b>L CHILDREN WITH COMPLEX NEEDS REQUIRING CONTINUING CARE</b>			
The <i>National Framework</i> <sup>133</sup> is intended to provide guidance for CCGs when assessing the needs of children and young people whose complex needs cannot be met by universal or specialist health services. It takes into account recent changes where a child has SEND			

	and learning disabilities. From September 2014, this will require CCGs to jointly commission services for children with SEND with local authorities. CCGs will also need to co-operate with local authorities in ensuring that single assessments and EHCP are put in place. EHCPs will be for children who have learning difficulties and disabilities, which result in special educational needs – therefore including some children who need CPC.		
	<i>Standard</i>	<i>Evidence</i>	<i>Ref</i>
125	Families, children and young people with complex needs should have access to the full range of multidisciplinary services to support planned and timely discharge from acute care, including the capacity to provide a reliable/sustainable care package for children who are technology dependent, to facilitate earlier discharge from hospital and enable them to lead as normal a life as possible. This should include a pharmacist which in most cases will be the family's regular community pharmacist, and relevant AHPs.	Operational policy Monitoring of delayed treatment of care Discharge pathway	19, 43
126	There should be close working with health co-providers, especially local hospital paediatric services and CAMHS as well as education and social care services.	Operational policy	15
127	The care and support of young people with complex needs are considered in the context of their cognitive ability and developmental needs. This should include assessment of physical, psychological and emotional needs.	Evidence of assessments	39
128	Clear protocols are in place to facilitate/support access to hospital care and support hospital and community staff when children who have complex care needs and are normally cared for at home require admission to hospital to ensure the child is looked after by safe competent staff in the hospital environment.	Protocols and policy	19, 20, 85
129	Every parent or carer of a child with complex health needs should be made aware of their rights to access respite care (short breaks) and benefits. There should be a range of respite provision and other relevant local support services.	Review of case notes Evidence of short breaks offer from local authority	45

## M MULTIDISCIPLINARY TEAM

Children's health care is best delivered through a multidisciplinary team, with the GP at the centre collaborating with stakeholders, including local voluntary and authority partners, community care and acute care.<sup>18</sup> The MDT includes school nursing, GPs, community pharmacy, continuing healthcare nursing, CAMHS, psychology, OT, physiotherapy, dietetics, speech and language therapy, voluntary sector, community paediatric and district nursing teams.

	<i>Standard</i>	<i>Evidence</i>	<i>Ref</i>
130	Patients identified for coordinated care should receive regular multidisciplinary reviews by a team involving health and care professionals with the necessary skills to address their needs. The frequency and range of disciplines involved will vary according to the complexity and stability of the patient and as agreed with the patient/carer.	Evidence of multi-disciplinary audit	37

## N MEDICINES OPTIMISATION

Having skills around reducing errors of medication will support parents and children and young people<sup>86</sup> Access to medicines should be co-ordinated between settings and assumptions should not be made that all medicines are readily available within local community pharmacy networks.

	<i>Standard</i>	<i>Evidence</i>	<i>Ref</i>
131	There are systems in place to minimise prescription and drug administration errors. This includes: <ul style="list-style-type: none"> <li>➤ Utilising current systems to monitor adherence to national and local prescribing guidelines</li> <li>➤ Development or identifying appropriate education and training resources to support adherence to prescribing guidelines</li> <li>➤ Utilising current systems to monitor near misses and medication errors in primary and community care settings</li> </ul>	Organisational policy British National Formulary for children available Processes in place to minimise errors, reporting and review of errors and near misses and to spread learning Adherence to CQC standards in medicines management	31, 40, 44, 52, 53, 54, 56, 92, 126, 134
132	CYP should have equity of access to medicines optimisation services in primary	Policy for medicines use	31, 52, 53, 54, 56

	care, such as medicines use reviews in community pharmacies or medication reviews in GP practices or community clinics.	reviews	
133	Community pharmacists should be included in communications between clinical settings to ensure they have enough information to advise the family of the safe use of prescribed medicines and to advise on the purchase of over the counter medicines for self-care.	Evidence of communication methods Audit of near misses	56, 123, 134
134	Utilisation of minor ailments services should be considered to improve access to medicines and advice for the treatment of minor ailments in CYP thus reducing the need to see the GP or use OOH or ED services.	Minor ailment policy	135, 136
135	The use of Patient Group Directions (PGD) medicine supply services in community pharmacies or the expansion of established PGD services in other primary care settings should be considered to improve access to medicines for CYP.	PGD policy	137, 138, 139

## Appendix 1: Glossary

AHPs	Allied Health Professionals
APLS	Advanced paediatric life support
BMI	Body mass index
CAMHS	Child and adolescent mental health services
CCGs	Clinical Commissioning Groups
CCN	Community children's nurse
CDOP	Child death overview panels
CPC	Children's palliative care
CPD	Continuing professional development
CQC	Care Quality Commission
CSE	Child sexual exploitation
CYP	Children and young people
DGH	District general hospital
DH	Department of Health
DNA	Did not attend
ED	Emergency department
EHCP	Education, health and care plans
EPLS	European paediatric life support
GP	General Practitioner
HCA	Health care assistant
HLP	Healthy London Partnership
Hospital at Home	Hospital at Home provides safe, high-quality, hospital-level care to patients in the comfort of their own homes.
HWB	Health and Wellbeing Board
JSNA	Joint strategic needs assessment
KLOE	Key lines of enquiry
KPI	Key performance indicator
LAC	Looked After Children
LTC	Long term conditions
MDT	Multi-disciplinary team
MiDoS	My directory of services
NICE	National Institute of Health and Care Excellence
OOH	Out-of-hospital
OT	Occupational therapist
PAU	Paediatric assessment unit
PGD	Patient group direction
POSCUs	Paediatric Oncology Shared Care Units
RCN	Royal College of Nursing
RCPCH	Royal College of Paediatrics and Child Health
SEND	Special educational needs and disabilities
STI	Sexually transmitted infection
UCC	Urgent care centre
UNCR	United Nations convention of the rights of a child
Virtual Ward	The Virtual Ward operates in the same way as a normal hospital ward, the difference is the patient stays comfortably and safely in their own home
WTE	Whole time equivalent
WTtSC	Working Together to Safeguard Children

## Appendix 2: Role of the care coordinator

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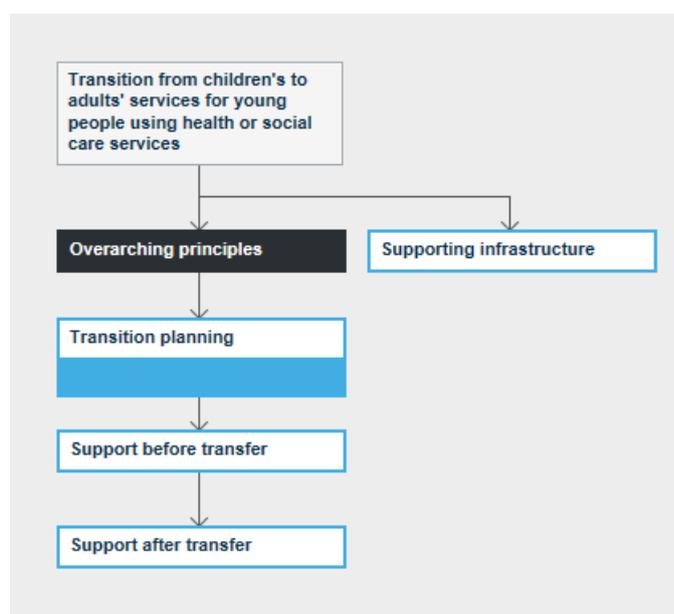
The care coordinator's role may include:

- Ensuring information is shared between respective professionals and other professionals via different methods for example face to face, written reports, hand-held records, telephone consultation, email, telemedicine, links to websites, evidence-based information and web links to 'self-help' groups
- Sharing information with the young person and family
- Recording where and when information is shared
- Sharing information and data with national registers and databases as appropriate respecting patient confidentiality
- Ensuring information can be shared out of hours on weekdays and at weekends
- Coordinating timely reassessment and review of care. This should include a review of who is involved in the child or young person's care
- Agreeing who is present during information sharing and what their roles and responsibilities are
- Ensuring that it is clear who is supporting and leading each step of the child or young person's journey
- Ensuring the child or young person and his or her family know whom to contact during the normal working day and out of hours during the weekday and at weekends
- Ensuring any handover actions are shared in a timely way with the child or young person and professionals involved, and documented in the child or young person's care plans
- Ensuring that the child or young person receives clear information about who is in charge if a change of professional or organisation is made
- Ensuring that it is clear to the child or young person and his or her family when responsibility and accountability is transferred on the child or young person's journey at each stage in the pathway from one professional to another. This is made explicit to all of the professionals involved

## Appendix 3: NICE transition pathway and principles

Taken from NICE (2016) Transition from children's to adults' services for young people using health or social care services <https://www.nice.org.uk/guidance/ng43>

### Transition to children's to adult's services overview - pathway



### Overarching principles

1.1.1 Involve young people and their carers in service design, delivery and evaluation related to transition by:

- Co-producing transition policies and strategies with them
- Planning, co-producing and piloting materials and tools
- Asking them if the service helped them achieve agreed outcomes
- Feeding back to them about the effect their involvement has had

1.1.2 Ensure transition support is developmentally appropriate, taking into account the person's:

- Maturity
- Cognitive abilities
- Psychological status
- Needs in respect of long term conditions
- Social and personal circumstances
- Caring responsibilities
- Communication needs

1.1.3 Ensure transition support:

- Is strengths-based and focuses on what is positive and possible for the young person rather than on a pre-determined set of transition options
- Identifies the support available to the young person, which includes but is not limited to their family or carers

#### 1.1.4 Use person-centred approaches to ensure that transition support:

- Treats the young person as an equal partner in the process and takes full account of their views and needs
- Involves the young person and their family or carers, primary care practitioners and colleagues in education, as appropriate
- Supports the young person to make decisions and builds their confidence to direct their own care and support over time
- Fully involves the young person in terms of the way it is planned, implemented and reviewed
- Addresses all relevant outcomes, including those related to:
  - ❖ education and employment
  - ❖ community inclusion
  - ❖ health and wellbeing, including emotional health
  - ❖ independent living and housing options
- Involves agreeing goals with the young person
- Includes a review of the transition plan with the young person at least annually or more often if their needs change

1.1.5 Health and social care service managers in children's and adults' services should work together in an integrated way to ensure a smooth and gradual transition for young people. This work could involve, for example, developing:

- A joint mission statement or vision for transition
- Jointly agreed and shared transition protocols, information sharing protocols and approaches to practice

1.1.6 Service managers in both adults' and children's services, across health, social care and education, should proactively identify and plan for young people in their locality with transition support needs.

1.1.7 Every service involved in supporting a young person should take responsibility for sharing safeguarding information with other organisations, in line with local information sharing and confidentiality policies.

1.1.8 Check that the young person is registered with a GP.

1.1.9 Consider ensuring the young person has a named GP.

## Appendix 4: Additional reading

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- Child health surveillance information, Department of Health (2009), Healthy Child Programme | <https://www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life>
- NHS East of England (2010), Developing workforce models for Children's Assessment Unit provision across the East of England | [Developing workforce models for children's assessment unit provision across East of England](#)
- British Journal of General Practice (2015), Childhood long-term conditions in primary care: a qualitative study of practitioners' views | <http://bjgp.org/content/65/638/e593>
- National Quality Board (2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable and productive staffing | [Safe, sustainable and productive staffing](#).
- Department of Health (2001) Seeking Consent: Working with Children | [Seeking consent: working with children](#)
- Department of Health (2011) You're Welcome - Quality criteria for young people friendly health services | <https://www.gov.uk/government/publications/quality-criteria-for-young-people-friendly-health-services> These standards are being updated
- Department of Health (2003) Confidentiality: NHS Code of practice | [Confidentiality: NHS Code of practice](#)
- Department of Health (2004) Best Practice Guidance for Doctors and Other Health Professionals on the Provision of Advice and Treatment to Young People Under 16 on Contraception, Sexual and Reproductive Health | [Best practice guidance](#)

## Appendix 5: References

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- <sup>1</sup> Healthy London Partnership Children and Young People's Programme (2016) Compendium: New models of care for acutely unwell children and young people
- <sup>2</sup> British Medical Journal Quality improvement report 4 (2015) The development and evaluation of community respiratory service for children with severe neurodisability; Wolff et al | <http://qir.bmj.com/content/4/1/u208552.w3411.abstract?related-urls=yes/4/1/u208552.w3411>
- <sup>3</sup> APCP (2016) The Development of Nasopharyngeal Suction Guidelines and Competency Pack for Parents and Carers of Children with Chronic Respiratory Morbidity or Illness; C. Egan, A. Hipwell | <http://apcp.csp.org.uk/group-journal/apcp-journal-volume-7-number-1>
- <sup>4</sup> Her Majesty's Government (2004) Children Act 2004 c.31, Part 2, General, Section 11 | [www.legislation.gov.uk/ukpga/2004/31/pdfs/ukpga\\_20040031\\_en.pdf](http://www.legislation.gov.uk/ukpga/2004/31/pdfs/ukpga_20040031_en.pdf)
- <sup>5</sup> Her Majesty's Government (2013) Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children | <https://www.gov.uk/government/publications/working-together-to-safeguard-children--2>
- <sup>6</sup> Healthy London Partnership Children and Young People's Programme (2016) Improving care for children and young people with mental health crisis in London: Recommendations for transformation in delivering high quality accessible care
- <sup>7</sup> Kings Fund (2016) Bringing together physical and mental health: A new frontier for integrated care | <http://www.kingsfund.org.uk/publications/physical-and-mental-health>
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