

D09/S/b

**NHS STANDARD CONTRACT  
FOR IMPLANTABLE HEARING AIDS FOR MICROtia, BONE ANCHORED  
HEARING AIDS AND MIDDLE EAR IMPLANTS (ALL AGES)**

**SCHEDULE 2, THE SERVICES – A. SERVICE SPECIFICATIONS**

|                                  |  |
|----------------------------------|--|
| <b>Service Specification No.</b> | D09/S/b  |
| <b>Service</b>                   | Implantable Hearing Aids for Microtia, Bone Anchored Hearing Aids and Middle Ear Implants (All Ages) |
| <b>Commissioner Lead</b>         |  |
| <b>Provider Lead</b>             |  |
| <b>Period</b>                    | 12 months  |
| <b>Date of Review</b>            |  |

## 1. Population Needs

### 1.1 National/local context and evidence base

It is estimated that there are approximately 7.5 million people in England with mild to moderate hearing loss. There are an additional 575,000 with severe to profound hearing loss. The majority of all adult hearing loss is age related [presbycusis] but it may also be caused by excessive exposure to noise, ototoxic drugs, metabolic disorders, infections, injury or genetic factors.

Evidence indicates that in adults with a mild hearing loss 20 % have a conductive component, rising to 30% with a conductive component for those with losses that are moderate, severe or profound (Davis et al, 2009).

There are also adults who acquire a unilateral profound hearing loss. For example, the British Association of Otorhinolaryngologists Head and Neck Surgeons (BAO HNS) estimate 90 % of patients with an acoustic neuroma (AN) will have a unilateral progressive hearing loss (2002). A 2005 study by Lin et al suggested the prevalence of incidental acoustic neuromas to be 2 in 10,000. The detection levels of these tumours is thought to be improving through improved Magnetic resonance imaging (MRI) techniques, as ANs which would have previously been too small to be detected are now being identified.

The prevalence of permanent hearing loss in childhood [greater than 40dB] is estimated at 1.65 per 1000 live births rising to 2.05 per 1000 live births in children over 9 years of age (Fortnum et al, 2001).

The incidence of congenital atresia of the external auditory canal with associated middle ear abnormality is estimated at 1: 10000 live births with between 15 and 305 of these being bilateral.

As prevalence of deafness is strongly associated with older age and due to the aging population profile in England, the numbers of those with severe to profound deafness can be predicted to increase. There are more females than males with hearing loss although this is associated with females living longer rather than gender differences in causes of deafness. Some minority ethnic groups may have higher rates of hearing loss due to increased genetic risk associated with consanguinity and increased risk of childhood infections. Approximately 40% of children who are deaf and 45% of people younger than 60 years who are deaf have additional difficulties, such as other physical or sensory disabilities.

The first and preferred method of rehabilitating all of the above types of hearing loss is to use an air conduction hearing aid (ACHA). If an ACHA is not providing suitable habilitation or rehabilitation then an appropriate implantable hearing device should be considered. The absence of an external ear to use an ACHA is a clear indication. Other common indications relate to chronic discharge from an ear. For example otitis externa or chronic suppurative otitis media which cannot be resolved by medical treatments in the presence of an ACHA.

Children with microtia have cosmetic as well as hearing aspects to be managed. It is vital that these are considered together in the overall context of the individual's management.

## **2. Scope**

### **2.1 Aims and objectives of service**

The aim of a hearing implant rehabilitation centre is to improve the hearing and quality of life for those with permanent deafness who are unable to benefit from conventional well-fitted ACHAs.

The service will deliver the aim by:

- Providing equitable access for all eligible children and adults
- Providing a service which is clinically and cost effective
- Providing appropriate long term support and aftercare

Additional considerations for paediatric caseload

Aims for paediatric rehabilitation:

- To ensure that those individuals with microtia have access to support and treatment for their hearing and cosmetic aspects provided in a coordinated fashion by a single team or two teams working in a coordinated way.

## 2.2 Service description/care pathway

The Services included are :

- Percutaneous bone anchored hearing aids
- Active implants for bone & ossicular conduction or other means of direct external mechanical cochlear stimulation
- Auditory implantation in microtia (excluding Cochlear Implantation)

A hearing implant team must function as part of a wider service of ACHA fitting and rehabilitation services for children, adults and teenagers. As the assessment and rehabilitation required to support successful use of hearing implants can be highly complex, these services will be provided by either a hearing implant centre or on an outreach/shared care basis where appropriate.

All team members must be suitably qualified and registered with appropriate professional bodies and comply with the relevant requirements. All members must maintain continued professional development (CPD) and appraisal. All will have training in deaf awareness and knowledge of the full range of ACHA and implantable devices offered by their service.

Clinical team members will attend regular training in developments within the field of hearing implantation. Attendance at relevant courses, conferences and meetings at national and international levels is desirable.

Newly appointed members of the team who are less experienced must undergo an appropriate programme of induction and training with supervision provided by relevant experienced members of the hearing implant team. All team personnel must maintain a programme of continued professional development to ensure on-going competency.

Patients will receive an initial assessment to ensure they have been fitted with the most suitable ACHA using real ear measurements, wireless contralateral routing of signal (CROS) or binaural CROS (BiCROS) aids and hypoallergenic ear moulds as appropriate. If after all ACHA alternatives have been trialled, and careful review, ACHAs are not suitable for the patient, then a hearing implant may be considered.

All patients will undergo comprehensive assessment by a specialist multi-disciplinary team to assess suitability for hearing implantation. As a minimum all units must be able to offer all types of hearing implants (excluding brain stem implants) or must be part of an agreed network with a unit that does offer all hearing implants so as to ensure patients can be fitted with the most appropriate device for their hearing loss.

Assessment will include:

- Audiological assessments (otoscopy, tympanometry, age-appropriate hearing assessments and speech testing, speech in noise testing and objective hearing assessments as appropriate)
- Patient / family / carer understanding and expectations of implantation and informed consent
- Medical assessments (clinical history, physical examination, fitness for surgery,

suitability of anatomical site for implantation, MRI, computed tomography (CT) scan as required)

Assessments for the hearing rehabilitation of children with microtia will be coordinated with the views of the wider team responsible for the cosmetic aspects of care.

The service will ensure access to further appropriate services and care for patients with complex and special needs.

Assessments for bone anchored hearing aids (BAHAs) must include a minimum of 5 day trial with a loan device in the relevant home, social, work and learning environments. This trial must be supported by suitable tools for assessment of benefit by the patient including pre- and post- trial evaluations e.g. outcome questionnaires such as the client oriented scale of improvement (COSI), Glasgow hearing aid benefit profile (GHABP) and Bern Benefit in Single-Sided Deafness Questionnaire

Assessments for middle ear implants must include an identical trial of a BAHA as outlined above together with an assessment with a direct drive stimulator (when appropriate) with mechanisms to record the patient outcomes.

Wireless CROS or BiCROS aids must be available home trial for patients who are suitable for these devices

As part of the assessment process, patients who may be candidates for hearing implants and their families / carers as appropriate, will receive information about voluntary services and support groups including opportunity to have contact with deaf patients of a similar age (and their families for paediatric patients) who are users of hearing implants, either face to face or via alternative media. Patients will be offered written information to help them to make informed decisions about their healthcare, at appropriate points within the assessment.

If the outcome of the assessment demonstrates that the patient would not benefit from a hearing implant, the report to the referring agent will include:

- Reasons why a hearing implant is considered to be unsuitable.
- Recommendations for future management, and referral for other equipment and /or services if appropriate.

Adults will demonstrate that they have realistic expectations of hearing implantation, e.g. by clear record of the discussion relating to expectations.

The hearing implant device offered will:

- Have a proven track record for safety
- Have Conformité Européenne (CE) approval
- Conform to the recommendations of the Medical and Health Care Products Regulatory Agency
- Comply with terms and conditions of the purchasing body
- Have high quality clinical and technical support available from the manufacturer
- Meet national purchasing requirements

The in-patient episode will include the following:

- The operation - completed by an experienced, specialist Ear Nose and Throat (ENT) Consultant Surgeon. Implantation must be carried out by appropriately qualified surgeons who have an adequate caseload to maintain surgical skills and optimise outcomes.
- Surgical facilities must afford appropriate NHS standards of safety, accessibility, cleanliness, privacy and dignity and also take into account communication needs of deaf patients.

Prior to discharge the patient will receive:

- Written information regarding care of the wound/ear and pain management post operatively
- Written guidelines on what to do should medical /surgical problems arise.
- Advice regarding health and safety with a hearing implant

The service will ensure that the more intensive rehabilitation needs of the patient will be appropriately addressed.

Rehabilitation requirements include:

- Medical check following implantation of surgical site and device placement and functioning
- Activation and programming of device using in situ measurements will be performed at the initial fitting appointment. Verification of the amplification of sound should also be performed eg speech testing and adjusted when it is not optimal.
- On-going sound programming and assessment dependent on individual need
- After the first year following surgery, the patient will be offered regular audiological review, typically annually in the first instance. Flexibility for additional appointments will be available if required to adequately meet the needs of the patient
- Training and advice to patient (and carers if appropriate) on care and use of the implant
- Advice to other organisations e.g. trouble shooting advice for local staff (for children)
- On-going support and maintenance – including a comprehensive spares and repairs service
- Medical – access to the implant medical / surgical /specialist nursing team as required
- Ensure patient has access to up to date technology to maximise their hearing performance and subsequently outcome from the intervention.

Patients and or carers will be trained by the service to carry out simple trouble-shooting and maintenance such as visual inspection of external parts and subjective listening checks (where possible). For more complex maintenance needs, the hearing implant service will provide advice via telephone, fax, e- mail, text etc. and make arrangements whereby external implant parts can be brought or posted to the service during opening hours. The service will aim to resolve simple repair issues within 2 working days. Where devices need to be sent for repair, they will be

returned to the patient within 7 days. Replacements of external equipment will be provided as appropriate. Batteries will be available to implant users either from the hearing implant programme or from a local audiology department by prior agreement.

Patients will be advised they have access to urgent medical support as required through Accident & Emergency 24 hours per day.

The service will have appropriate policies which cover, as a minimum:

- Device failure
- Lost devices
- FM policy and Assistive Devices
- Upgrade of devices
- Transfer of care pathway from/to another service

The service will provide re-implantation if required. Costs outside those included in the manufacturer's warranty are the responsibility of the commissioner.

Essential repairs, consumables and spare parts will be provided free of charge to users. Users may be asked to pay for non-essential items e.g. decorative covers and for repair or replacement of parts or devices if damage, loss or failure is determined to be due to inappropriate care, with appropriate provision for appeal.

If, following a multi-disciplinary team assessment, it is determined that patients are not suitable for a hearing implant, the service will ensure that:

- The patient and/or the family have the opportunity to discuss the outcome of the assessment.
- The referrer, the local audiology department, other relevant professionals and the patient's General Practitioner (GP) are notified of the decision and the future management plan.

Records of measurement of all programmes installed in the software, and of all tests performed by the multi-disciplinary team, must be kept. Progress with the hearing implant will be monitored through at least two assessments in the first year and then again at routine reviews. These tests will include the patient's ability to hear sounds and speech, as well as assessment of quality of life.

All records and measurements will be available on request and provided, with consent to other parties, who may have a legitimate reason for using them, e.g. education, health services etc. The service will engage in audit and monitoring of service outcomes with data shared with commissioners and appropriate external organisations. Guidance on a minimum dataset is provided at the end of this specification in section 4.

The following are over-arching principles that are to be applied to each provider delivering a hearing implantation service:

- Consideration must be given to the needs of a deaf population in all aspects of the design of the service.
- There must be clearly defined clinical and managerial accountability within the

service.

Unless alternatively specified in this document, providers are expected to meet the following quality standards for age-appropriate services:

- Quality Standards: Bone anchored hearing aids for children and young people: guidelines for professional working with young children: National Deaf Children's Society (2010)

Where elements of the hearing implant service are sub-contracted to another provider, there must be clear and formal accountability processes and structures in place to ensure continuity of clinical care that is safe and effective. All subcontracting agreements have to be agreed in advance with the commissioners. The contract with the provider and the subcontractor will mirror the standard NHS contract (or successor documents) with the provider and the commissioner. Sub-contractors will be expected to provide services of the same level and quality of service as the centre.

### **General Paediatric care**

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

### **2.3 Population covered**

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

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

### **2.4 Any acceptance and exclusion criteria**

Adults and children with permanent hearing loss requiring hearing assistance in whom it is determined conventional air conduction hearing aid (ACHA) cannot be used after a suitable fitting and trial.

The service will accept referrals from:

- GP
- NHS or private Audiology Service
- Ear, Nose and Throat (ENT) Service
- Paediatrician
- Teacher of the Deaf

Written referrals will be made to the hearing implantation service providing evidence of:

- Unaided hearing level in both ears at frequencies 0.5 - 4 kHz (masked where needed) for air conduction, and not masked bone conduction thresholds (for babies and young children this may not be possible to assess fully prior to referral)
- Where possible, evidence of an ACHA trial with real ear measurements and suitable ear moulds of at least 6 weeks or a reason as to why this is contraindicated or inappropriate.

When considering the assessment of adequacy of ACHA, the multidisciplinary team must be mindful of the need to ensure equality of access. Tests will take into account a person's disabilities (such as physical and cognitive impairments), or linguistic or other communication difficulties, and may need to be adapted. If it is not possible to administer tests in a language in which a person is sufficiently fluent for the tests to be appropriate, other methods of assessment will be considered. Providers will be expected to monitor uptake of services to assess equity of access.

## **2.5 Interdependencies with other services**

There are no required collocations. The service will interact with the following other services:

- Primary Care
- NHS Audiology Service
- NHS Newborn Hearing Screening Programme
- Appropriate rehabilitative services which may include Speech & Language Therapy, Hearing Therapy, Educational Services including Teacher of the Deaf or other specialist teaching services, Social Services including Social worker for the deaf, Occupational therapy, Physiotherapy, and Psychology.

## **3. Applicable Service Standards**

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

Services should be aware of the recommendations in "Adult bone anchored hearing-aid services in the UK: Building a consensus for development". The recommendations in this document are recognised as good practice and services are encouraged to implement them.

The National Deaf Children's Society (NDCS) has a quality standard for bone anchored hearing aids for children and young people, which was updated in

2010. Services should conform to these standards.

### **Core Standards**

- Hearing Implant Services must have access to appropriately calibrated and up-to- date equipment and facilities to enable all appropriate assessments to be undertaken. Audiological testing will be performed in appropriately sound treated rooms where possible such that the ambient noise levels are compliant with the BBS EN ISO 8253-1:1998 standard, Acoustics: - Audiometric test Methods – part 1.
- Facilities will afford appropriate NHS standards of safety, accessibility, cleanliness, privacy and dignity and also take into account communication needs of deaf patients and requirements for specific assessments such as sound-proofing. The design and layout will take into account the needs of families and young children within their client group. Services, facilities and accommodation must comply with current British standards and the Equality Act 2010. All facilities must comply with Health and Safety Executive regulations.
- Assessments for BAHAs must include a minimum of 5 day trial with a loan device in the relevant home, social, work and learning environments. This trial must be supported by suitable tools for assessment of benefit by the patient including pre- and post- trial evaluations e.g. outcome questionnaires such as the COSI, Glasgow Hearing Aid Benefit Profile (GHABP) and Bern Benefit in Single-Sided Deafness Questionnaire.
- All patients must have completed the trial of a “conventional air conduction hearing aid” (unless not anatomically possible) and have a clear inability to use such an aid before entering a hearing implant programme.

| <b>4. Key Service Outcomes</b> |  |   |                              |                              |
|--------------------------------|--|---|------------------------------|------------------------------|
| <b>Performance Indicator</b>   | <b>Indicator</b>   | <b>Threshold</b>  | <b>Method of Measurement</b> | <b>Consequence of Breach</b> |
| Information                    | Percentage of patients receiving appropriate information   | 100%  | Annual Audit                 | Report & remediation plan    |
| Successful Surgery BAHA        | Percentage of patients reporting abutment loss during past 5 years   | 5% adult<br>7% children   | Annual Audit                 | Report & remediation plan    |
|                                | Percentage of patients requiring revision of local skin graft within 1 year of surgery   | 5%  | Annual Audit                 |                              |
| User satisfaction              | Percentage of users reporting themselves be satisfied or very satisfied with their implant 12 months after surgery using a validated questionnaire | 90% of patients reporting themselves to be satisfied or very satisfied with their implant | Annual Audit                 | Report & remediation plan    |
| Quality of life                | Service to present evidence of outcomes monitored  | Improvements to be seen   | Annual Audit                 | Report & remediation plan    |

## ANNEX 1 TO SERVICE SPECIFICATION

### PROVISION OF SERVICES TO CHILDREN

#### 2. Scope

##### 2.1 Aims and objectives of service

This specification annex applies to all children's services and outlines generic standards and outcomes that would be fundamental to all services.

The generic aspects of care:

The Care of Children in Hospital (HSC 1998/238) requires that:

- Children are admitted to hospital only if the care they require cannot be as well provided at home, in a day clinic or on a day basis in hospital.
- Children requiring admission to hospital are provided with a high standard of medical, nursing and therapeutic care to facilitate speedy recovery and minimize complications and mortality.
- Families with children have easy access to hospital facilities for children without needing to travel significantly further than to other similar amenities.
- Children are discharged from hospital as soon as socially and clinically appropriate and full support provided for subsequent home or day care.
- Good child health care is shared with parents/carers and they are closely involved in the care of their children at all times unless, exceptionally, this is not in the best interest of the child; Accommodation is provided for them to remain with their children overnight if they so wish.

##### 2.2 Service description/care pathway

All paediatric specialised services have a component of primary, secondary, tertiary and even quaternary elements.

The efficient and effective delivery of services requires children to receive their care as close to home as possible dependent on the phase of their disease.

Services should therefore be organised and delivered through "integrated pathways of care" (National Service Framework for children, young people and maternity services (Department of Health & Department for Education and Skills, London 2004)

##### 2.5 Interdependencies with other services

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

## Imaging

All services will be supported by a 3 tier imaging network („Delivering quality imaging services for children DOH 13732 March2010). Within the network:

- It will be clearly defined which imaging test or interventional procedure can be performed and reported at each site
- Robust procedures will be in place for image transfer for review by a specialist radiologist, these will be supported by appropriate contractual and information governance arrangements
- Robust arrangements will be in place for patient transfer if more complex imaging or intervention is required
- Common standards, protocols and governance procedures will exist throughout the network.
- All radiologists, and radiographers will have appropriate training, supervision and access to CPD
- All equipment will be optimised for paediatric use and use specific paediatric software

## Specialist Paediatric Anaesthesia

Wherever and whenever children undergo anaesthesia and surgery, their particular needs must be recognised and they should be managed in separate facilities, and looked after by staff with appropriate experience and training.<sup>1</sup> All UK anaesthetists undergo training which provides them with the competencies to care for older babies and children with relatively straightforward surgical conditions and without major co-morbidity. However those working in specialist centres must have undergone additional (specialist) training<sup>2</sup> and should maintain the competencies so acquired<sup>3</sup> \*. These competencies include the care of very young/premature babies, the care of babies and children undergoing complex surgery and/or those with major/complex co-morbidity (including those already requiring intensive care support).

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

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

\*The Safe and Sustainable reviews of paediatric cardiac and neuro- sciences in England have noted the need for additional training and maintenance of competencies by specialist anaesthetists in both fields of practice.

## References

1. Guidelines for the Provision of Anaesthetic Services (GPAS) Paediatric anaesthetic services. Royal College of Anaesthetists (RCoA) 2010  
[www.rcoa.ac.uk](http://www.rcoa.ac.uk)
2. Certificate of Completion of Training (CCT) in Anaesthesia 2010
3. CPD matrix level 3

## Specialised Child and Adolescent Mental Health Services (CAMHS)

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

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

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

## 3. Applicable Service Standards

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

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

- There must be at least two Registered Children's Nurses (RCNs) on duty 24

hours a day in all hospital children's departments and wards.

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

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

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

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

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

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

Children and young people must only receive a service from a provider who takes steps to prevent abuse and does not tolerate any abusive practice should it occur (Outcome 7 Essential Standards of Quality and Safety, Care Quality Commission, London 2010 defines the standards and evidence required from providers in this regard). Providers minimise the risk and likelihood of abuse occurring by:

- Ensuring that staff and people who use services understand the aspects of the safeguarding processes that are relevant to them.
- Ensuring that staff understand the signs of abuse and raise this with the right person when those signs are noticed.
- Ensuring that people who use services are aware of how to raise concerns of abuse.
- Having effective means to monitor and review incidents, concerns and

complaints that have the potential to become an abuse or safeguarding concern.

- Having effective means of receiving and acting upon feedback from people who use services and any other person.
- Taking action immediately to ensure that any abuse identified is stopped
- and suspected abuse is addressed by:
  - having clear procedures followed in practice, monitored and reviewed that take account of relevant legislation and guidance for the management of alleged abuse.
  - separating the alleged abuser from the person who uses services and others who may be at risk or managing the risk by removing the opportunity for abuse to occur, where this is within the control of the provider.
  - reporting the alleged abuse to the appropriate authority.
  - reviewing the person's plan of care to ensure that they are properly supported following the alleged abuse incident.
- Using information from safeguarding concerns to identify non-compliance, or any risk of non-compliance, with the regulations and to decide what will be done to return to compliance.
- Working collaboratively with other services, teams, individuals and agencies in relation to all safeguarding matters and has safeguarding policies that link with local authority policies.
- Participates in local safeguarding children boards where required and understand their responsibilities and the responsibilities of others in line with the Children Act 2004.
- Having clear procedures followed in practice, monitored and reviewed in place about the use of restraint and safeguarding.
- Taking into account relevant guidance set out in the Care Quality Commission's Schedule of Applicable Publications
- Ensuring that those working with children must wait for a full CRB disclosure before starting work.
- Training and supervising staff in safeguarding to ensure they can demonstrate the competences listed in Outcome 7E of the Essential Standards of Quality and Safety, Care Quality Commission, London 2010

All children and young people who use services must be

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

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

#### **4. Key Service Outcomes**

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

Poorly planned transition from young people's to adult-oriented health services can be associated with increased risk of non-adherence to treatment and loss to follow-up, which can have serious consequences. There are measurable adverse consequences in terms of morbidity and mortality as well as in social and educational outcomes. When children and young people who use paediatric services are moving to access adult services (for example, during transition for those with long term conditions), these should be organised so that:

- All those involved in the care, treatment and support cooperate with the planning and provision to ensure that the services provided continue to be appropriate to the age and needs of the person who uses services.

The National Minimum Standards for Providers of Independent Healthcare, (Department of Health, London 2002) require the following standards:

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

All hospital settings should meet the Standards for the Care of Critically Ill Children (Paediatric Intensive Care Society, London 2010).

There should be age specific arrangements for meeting Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These require:

- A choice of suitable and nutritious food and hydration, in sufficient quantities to meet service users' needs;
- Food and hydration that meet any reasonable requirements arising from a service user's religious or cultural background
- Support, where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs.
- For the purposes of this regulation, "food and hydration" includes, where applicable, parenteral nutrition and the administration of dietary supplements where prescribed.
- Providers must have access to facilities for infant feeding, including facilities to support breastfeeding (Outcome 5E, of the Essential Standards of Quality and Safety, Care Quality Commission, London 2010)

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

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

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

- Ensures the medicines given are appropriate and person-centred by taking account of their age, weight and any learning disability
- Ensuring that staff handling medicines have the competency and skills needed for children and young people's medicines management
- Ensures that wherever possible, age specific information is available for people about the medicines they are taking, including the risks, including information about the use of unlicensed medicine in paediatrics.

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

- They are supported to have a health action plan
- Facilities meet the appropriate requirements of the Disability Discrimination Act 1995
- They meet the standards set out in Transition: getting it right for young people. Improving the transition of young people with long-term conditions from children's to adult health services. Department of Health, 2006, London