D01/S/c

NHS STANDARD CONTRACT
FOR COMPLEX DISABILITY EQUIPMENT: ENVIRONMENTAL CONTROLS (ALL AGES)

SCHEDULE 2 THE SERVICES – A. SERVICE SPECIFICATIONS

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<td>Complex Disability Equipment: Environmental Controls (All Ages)</td>
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1. Population Needs

1.1 National/local context and evidence base

Electronic Assistive Technology (EAT) is a term used to describe electronic equipment that can enable disabled people to live with a degree of independence in the community. This includes Environmental Control (EC) covered by this specification, Communication Aids (AAC) covered by Specification D1b and complex Wheelchair control systems, covered by Specification D1a. In some instances these functions may be required to be integrated together or work in conjunction. Environmental Control (EC) equipment enables the user control of functions or appliances primarily within the residential environment, but may also be used in other locations, such as school, college or workplace. The functions can include summoning help in an emergency, control door entry, make and receive telephone calls, operate electrical appliances and access computer technologies. With a modular format, the systems are prescribed and assembled to meet individual need and may include a custom manufactured or bespoke element.

Like other specialist equipment services, EC services are characterised by:
Complexity of patient needs (complex physical/cognitive/language/sensory disability often in combination).
- Need for awareness of the up to date range of EAT equipment options.
- Need for expert and independent assessment, as appropriate, by a multidisciplinary team.
• Patient and carer training to maximize effectiveness and independence.
• Timely review and re-assessment for changing needs.
• On-going and life-long maintenance of equipment and support for its operational use.

NICE has not issued specific guidance on EAT.

The National Service Framework for long term conditions has clearly identified the need to provide Equipment in Quality Requirement (QR) 7. QR 7 has recognised the role of EAT in enhancing independence, improving quality of life and in selected cases improve the opportunities for employment.

(http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4105369.pdf)

Specialist Services National Definitions Set (SSNDS) (3rdEdition 2010) has recognised that Specialised Commissioning Groups (SCG) should be commissioning EAT services.

(http://www.specialisedservices.nhs.uk/library/26/Assessment_and_Provision_of_Equipment_for_People_with_Complex_Philosophical_Disability_all_ages.pdf)


2. Scope

2.1 Aims and objectives of service

Aims

• To provide relevant EC equipment to adults and children with complex physical and other disabilities due to variety of medical conditions in order to improve their independence, quality of life, safety and participation.
• To participate with the provision of other EAT such as communication aids, powered wheelchair controls and other equipment of daily living, where this is appropriate.
• To collaborate with other clinical services and social agencies to optimise patient’s wellbeing.
• To ensure that patients and carers are well informed on the use of the equipment that has been loaned to them.
• To adapt equipment provision to meet the changing needs of the patient.
• To provide the service in an independent, unbiased, cost effective and accountable way.
• To ensure all staff within the service are trained to an adequate and relevant level of competency, including awareness of technological developments
• To promote the development and application of EC and other relevant EAT
Objectives

- Undertake assessment of individual patient’s EC needs by professionals with relevant competencies, working with, or alongside the service. This should include recommendations on equipment solutions and referral to other agencies as appropriate.
- Maintain access to a loan bank of appropriate EC equipment for assessment, trial and long term loan to patients.
- Provide equipment to meet individual patient’s independence goals.
- Support patient’s use of EC equipment by regularly reviewing them and their equipment requirements so as to meet changing needs and enable them to maintain a degree of independence.
- Ensure all equipment provided is maintained in a satisfactory state and checked in accordance with manufacturers’ recommendations.
- Health and social care professionals working in areas where service uptake is low are targeted and encouraged to refer those who could benefit from equitable equipment provision.

2.2 Service description/care pathway

The service will deliver environmental control and other related equipment as the specialist hub serving a catchment population typically in excess of two million people (Section 2.3).

Principle elements of the EC service

Staffing

The assessment and provision of EC equipment will be carried out by a multi-disciplinary team consisting of experienced professionals from a clinical / Allied Health Professional (AHP) background to ensure appropriateness and independence of prescription. All EC provider services will employ, or have reliable access to, properly accredited and experienced clinical scientists, rehabilitation physicians, clinical technologists, occupational therapists and speech and language therapists. Patterns of staffing will be determined by local requirements and the availability of skilled personnel.
The service will have as Clinical Lead an established clinician with relevant, proven competences and well versed in service organisation, innovation and research. The service will keep user related documentation securely in accordance with Trust and NHS guidelines.

Training

The service will ensure that they offer training packages, seminars and symposia to inform professionals (especially community occupational therapists, social workers, speech and language therapists) and voluntary sector personnel within its catchment. This will ensure that patients who could benefit from EC provision are referred to the service. EC and other EAT services across the country will collaborate to ensure equity of standards in prescription.

Care Pathway for EC service delivery

- Referrals will be accepted from health and social care professionals, charity support workers.
- 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).
- Additional information to the referral may be required from other sources and primarily the patient’s General Practitioner (GP), who is responsible for the care of the patient in the community, and is to be informed about the referral and its outcome.
- All referrals will be acknowledged within 10 days of receipt by the service and it be stated if there is reason to delay the assessment or referral acceptance, such as insufficient referral information.
- The service will assess the EC needs of all patients fulfilling the acceptance criteria.
- Patients will be assessed at their home, place of residence, hospital, school, or workplace as appropriate, by competent, experienced personnel and in collaboration with other services where necessary.
- Referral will be made to other services, such as other EAT services where appropriate.
- The assessment recommendations shall be confirmed in writing to the patient, referrer, GP and other stakeholders as appropriate.
- Opportunity for a temporary trial of suitable sample equipment shall be recommended and made available when indicated, such as when there is doubt over the patient’s motivation or ability to use the equipment.
- When equipment provision is recommended at the assessment, this will normally be available for use by the patient within 18 weeks of acceptable of the referral. Exceptions to this target may occur due to dependencies on other agencies or when the recommended solution involves custom, bespoke or integrated equipment.
- All patients provided with equipment shall receive adequate training in its use with necessary information in an appropriate format to them. Additional tuition shall be available as required, in consideration of the possible cognitive
• Patients using the equipment shall receive on-going technical support in case of its malfunction, an annual service maintenance visit including statutory testing of equipment.
• In response to reported malfunctions of the equipment, the service shall ensure that the user is contacted as soon as possible and remedial action for critical functions taken within 48 hours of notification.
• The frequency of user and equipment review shall be determined on a case by case basis by service personnel. Patients with rapidly deteriorating conditions, like Motor Neurone Disease (MND), will require more frequent reviews.
• Adjustments, modifications or change of the equipment provision shall be provided when indicated following review due to change in patient clinical condition, functional impairment or circumstances. A full re-assessment of their needs shall also be available when appropriate.
• Equipment no longer required by users due to change in their circumstances, shall be reclaimed, decontaminated and refurbished to standards agreed with manufacturers prior to becoming available for re-issue.

General Paediatric care

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

2.3 Population covered

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

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

The service is to be available to persons of all ages, diversities, medical conditions (acquired or congenital) and place of residence (independent living, with family, residential care, nursing home), who have a severe disability, which restricts their ability to operate independently standard handsets for control of the environment and access to computer technology.

A particular service will normally serve the population within a determined geographical area with a population size sufficient to generate the critical mass of referrals to support the service. Typically, this is a population of greater than 2 million.
2.4 Any acceptance and exclusion criteria

Most people requiring EC equipment have significant upper limb impairments that result in them being unable to use standard controls, for example remote-control handsets or telephones. Many are neurological conditions resulting in tetra-paresis, often with a progressive component varying from moderate to rapid and combined with fatigue. Many will also have impaired cognition and or communication function. The commonest diagnoses are as follows; Multiple sclerosis, Spinal Cord Injury (level C5/6 & above), Motor neurone disease, Cerebral palsy, Muscular dystrophy, Severe arthritis, Acquired Brain injury and Muscular dystrophy.

Environmental Controls provision will be for people who meet the following criteria:

- Profound and potentially complex physical disability, such that they are unable to operate standard controls for functioning independently in the home.
- Where simpler and cheaper non customised solutions are not suitable or appropriate.
- Cognitively and physically able to operate EC equipment consistently.
- Able to demonstrate sustained motivation to use the EC equipment.
- Individuals requiring multiple control functions integrated into a single means of access as multiple devices are inappropriate (including also potential for integrating functions for communication, computer access and/or powered wheelchair control.

Exclusion Criteria (for equipment provision by the service);

- Where simpler and cheaper non customised solutions to the identified needs of the patient are available and appropriate for the individual.
- The individual patient does not have the cognitive ability or motivation to operate the EC equipment. This shall normally be established through a period of trial of some sample solution of equipment.
- Provision of equipment is inappropriate due to social, environmental or other circumstances.

Given the nature of the medical conditions, compliance with the criteria may not be apparent from the referral information, and therefore are to be applied following the assessment.

Certain aspects of the potential provision are outside the funding remit of the specialist service and require referral for funding and provision by other agencies. If these are not available, then this may or may not preclude the benefit of provision of the EC equipment, these are:

- door, window and curtain openers
- page turners
- building adaptations
- electrical, joiner/carpentry or other minor adaptation
- telecare equipment

### 2.5 Interdependencies with other services

Relationships are required with other services and agencies where collaboration on assessment and/or provision for an individual patient is necessary, notably:

- Wheelchair services and communication aid services where equipment is required to be inter-connected or integrated.
- Local Community Equipment and Telecare services where equipment is required to be interconnected to allow its control by the patient through the EC equipment.
- Social services, housing associations or departments where minor adaptations works are required (e.g.: electrician or joinery/locksmith services).
- Specialist Nursing homes for patients with complex disabilities where they are likely to be resident for a significant period of time.

The following represent the additional stakeholders potentially involved in EAT service provision:

- Community Social Services, especially Occupational Therapy Service
- Community Rehabilitation Service/ Physical Disability Support Team
- Specialist Rehabilitation or treatment centres (Spinal Injury Units, Regional Rehabilitation Unit (RRU), National Hospital)
- Palliative Care Team & Consultant
- Consultants In Rehabilitation Medicine and Neurology
- Clinical Nurse Specialists (e.g.: Multiple Sclerosis)
- Charity support workers & organisations (e.g.: Motor Neurone Disease Association)
- Hospice & Respite centres
- Nursing & residential care homes
- Continuing Care Managers
- School, Colleges and Universities- Special Educational Needs

EC services across the country will collaborate to ensure service standards are maintained with equity. Collaboration is also required between EC services regarding individual patient equipment users who move place residence, so that their equipment and its support can be transferred.

EAT equipment may be obtained from suppliers in accordance with National Framework agreement for EAT operated by the NHS Supply Chain (Contract Ref: NF001365), which specifies the agreed process for the installation and on-going support of the equipment. Where utilised, EAT services are therefore required to liaise and work collectively with suppliers who provide equipment and services in accordance with the framework agreement and monitor their performance against this.

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

General Requirements

The following charge services to give people choice through services planned and delivered around their individual patient needs; to support people to live independently and play their full part in society; to coordinate partnership working between health and social services and other local agencies.

- National Service Framework (NSF) for long term conditions has clearly identified the need to provide Equipment in Quality Requirement (QR) 7. QR 7 has recognised the role of EAT in enhancing independence, improving quality of life and in selected cases improve the opportunities for employment
- Standards for Better Health
- NHS Improvement plan: Putting People at the Heart of Public Services.
- This sets a service model for long-term conditions through self-care, disease management and case management.
- Complying with requirement of other relevant Statutes e.g. Disability
- Discrimination Act and The Equality Act

Equipment related statutory requirements

- Ensuring that equipment is purchased and maintained in accordance with statutory requirements including Medicines and Healthcare Products Regulatory Agency (MHRA) regulations and manufacturer’s handbooks.

Quality standards

- National Framework agreement for EAT operated by the NHS Supply Chain (Contract Ref: NF001365), which specifies the agreed processes on suppliers for the installation and on-going support of the equipment.

4. Key Service Outcomes

Service Performance/ Accountability measures

- Assessment of an individuals needs and arrangement of equipment provision (where indicated) in a timely manner, with due consideration for their circumstances. Recording of compliance with 18 week delivery
- Regular review of provision to ensure continued meeting of patient needs and goals
- Service Activity level reporting (Numbers of referrals, assessment, provisions, reviews, adjustments, withdrawals) and relate to population levels and medical diagnosis.
Effectiveness outcome measures

- Identification of patient centred goals for provision and recording of their achievement or otherwise. Scaling and aggregating of outcome changes is possible.
- EC provision is intended to promote independence, safety, quality of life and participation for the individual. It can also impact on these dimensions and wellbeing for their carer and family.
- Indicators of these factors and means of recording changes may be developed but are as yet are not standardised for this population. The effect of changes in medical condition and other circumstances would have to be accommodated for in any such measure.
- EC and other EAT provision may make a significant, but not necessarily sole contribution to the one or more of the following patterns of life for the individual user;
  - continuing to live in their own home
  - employment (paid or voluntary)
  - education (certificated or otherwise)
  - participation in community or social activity (outside the home or via internet)
- Recording the number of equipment users where such a contribution is made and the duration of this, would serve as an indicator of outcome, until formal measures are developed.
ANNEX TO SERVICE SPECIFICATION

PROVISION OF SERVICES TO CHILDREN

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

Scope

Aims and objectives of service

The generic aspects of care

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

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

Service description/care pathway

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

Interdependencies with other services

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

All services will be supported by a 3 tier imaging network (‘Delivering quality imaging services for children’ Department of Health 13732 March 2010). Within the network;

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

Specialist Paediatric Anaesthesia

Wherever and whenever children undergo anaesthesia and surgery, their particular needs must be recognised and they should be managed in separate facilities, and looked after by staff with appropriate experience and training.1 All UK anaesthetists undergo training which provides them with the competencies to care for older babies and children with relatively straightforward surgical conditions and without major co-morbidity. However those working in specialist centres must have undergone additional (specialist) training2 and should maintain the competencies so acquired3. These competencies include the care of very young/premature babies, the care of babies and children undergoing complex surgery and/or those with major/complex co-morbidity (including those already requiring intensive care support).

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

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

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

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

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

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

Applicable Service Standards

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 2 RCNs 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)
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 Sexually Transmitted Infections (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:

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

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

- 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.