

**2013/14 NHS STANDARD CONTRACT
FOR PAEDIATRIC SURGERY: NEONATES**

SECTION B PART 1 - SERVICE SPECIFICATIONS

Service Specification No.	E02/S/c
Service	Paediatric Surgery: Neonates
Commissioner Lead	
Provider Lead	
Period	12 months
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

This specification should be read in conjunction with the Neonatal, Specialised Children's Surgery, Anaesthesia and Acute Pain Service, and the Specialised Paediatric generic specifications.

A neonate is normally defined as being 44 weeks post-conception age. For the purpose of surgery in babies the period is extended to 60 weeks post conceptual age when they have been born prematurely, because of the particular anaesthetic risks in this population and the requirement for specialist paediatric anaesthetists. Babies who lie outside this age group, or who are discharged from the neonatal services and subsequently need surgery, will be covered by the Specialised Children's Surgery/Anaesthetic and Acute Pain Service Specification.

The specification includes all the surgical sub-specialties, (i.e. paediatric general surgery, urology, orthopaedics, plastic surgery, neurosurgery, ophthalmic surgery, maxillofacial surgery, ear nose and throat (ENT)). Because of the level of complexity of many congenital conditions, more than one speciality is often involved in any given patient's care.

The specification includes conditions which are diagnosed antenatally for which surgical intervention is required.

A list (not intended to be exhaustive) of the neonatal conditions which may indicate surgery is listed in appendix 2.

Advances in technology and health care expertise have led to increasing survival rates of very premature babies over the last 20 years. Medical advances such as antenatal steroids; surfactant; improvements in nutrition; the evolution of neonatology as a paediatric sub-specialty; and the development of nursing expertise, mean that neonatal services continue to be an innovative and cutting edge area of medicine. (Neonatal Audit Office 2007).

Most babies are born healthy requiring little or no medical intervention. Every year, however, around 10% of babies are born prematurely or suffer from an illness or condition which requires care ranging in complexity from a local special care baby unit to a highly specialised neonatal intensive care department. Prematurity and illness in new-born babies are associated with a complex range of factors, including social deprivation, ethnicity and maternal age, assisted conception and lifestyle factors. Babies can also require care arising from complications of pregnancy and delivery; from medical disorders such as infection or metabolic disorders; or when surgical or other treatment is required for congenital abnormalities.

Surgical congenital abnormalities are uncommon. Around 3% of new-borns have a major physical anomaly. Around 60% of these affect the brain or heart and around 1% have multiple anomalies. Many of these will not require surgical intervention. Individual congenital conditions requiring intervention in the neonatal period are rare, e.g. Gastroschisis, which is one of the most common abnormalities, has an incidence of around 1 in 2,500. Less severe abnormalities are more common (e.g. inguinal hernias, about 1%) but do not always require specialist care.

The report of the Neonatal Intensive Care Services Review Group (April 2003) recommended a concentration of expertise in order to maximise the most effective delivery of services. The report reiterated the desire to see the majority of care delivered as close to home as possible, within re-organised managed clinical networks of care, which minimised the need for mothers and babies to travel long distances to receive care. Evidence suggests that networked models of care for intensive care produce the best outcomes for babies. The Neonatal Toolkit (2009), which includes a set of principles for quality neonatal services, and the House of Commons Public Accounts Committee report (2008), both endorse the principle of care being organised as part of a managed clinical network.

Therefore, neonatal surgery and anaesthesia will only take place in designated neonatal surgical centres, within a managed network of care. Neonatal surgery services will be co-located with neonatal intensive care units (NICUs), specialised paediatrics, specialist children's surgery/anaesthesia and maternity services.

Relevant Standards of Care & Policy Documents:

- British Association of Perinatal Medicine (BAPM) Service Standards (August 2010)
- Report of Department of Health Expert Working Group on Neonatal Intensive Care Services (2003)

- National Audit Office – *Caring for Vulnerable Babies* – (2007)
- House of Commons Public Accounts Committee – *Caring for Vulnerable Babies* (2008)
- Department of Health – *Toolkit for High Quality Neonatal Services* (2009)
- Royal College of Surgeons of England (2007) '*Surgery for children: Delivering a first class service*'. Available from the Royal College of Surgeons of England - www.rcseng.ac.uk2.
- Department of Health (2008) '*Commissioning safe and sustainable specialised paediatric services*'. Available from the Department of Health - www.dh.gov.uk
- Royal College of Paediatrics and Child Health (2004) '*Commissioning tertiary and specialised services for children and young people*'. Available from the Royal College of Paediatrics and Child Health - www.rcpch.ac.uk
- Association of Paediatric Anaesthetists, et al (2006) '*Joint statement on general paediatric surgery provision in district general hospitals*' on behalf of the Association of Paediatric Anaesthetists, the Association of Surgeons for Great Britain and Ireland, the British Association of Paediatric Surgeons, the Royal College of Paediatrics and Child Health, and the Senate of Surgery for Great Britain and Ireland. Available from The Royal College of Surgeons of England - www.rcseng.ac.uk
- Tanner, S (2007) '*Trends in children's surgery in England*' Arch Dis Child vol.92 pp.664-7. Available from - www.adc.bmj.com
- Royal College of Anaesthetists (2010) '*Guidelines for the provision of anaesthetic services*'. Available from the Royal College of Anaesthetists - www.rcoa.ac.uk
- Department of Health (2006) '*The acutely or critically sick or injured child in the district general hospital: a team response*'. Available from the Department of Health - www.dh.gov.uk
- National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) – '*Are We There Yet?: Surgery in Children*', (2011)
- '*The Future of Paediatric Pathology Services*', Royal College of Paediatrics and Child Health (March 2002)
- '*Improving Outcomes in Children and Young People with Cancer*' – National Institute for Health and Clinical Excellence (NICE), (2005)
- The British Association of Paediatric Surgeons – '*Paediatric Surgery: Standards of Care*' (2002)
- Royal College of Anaesthetists – '*Raising the Standard A Compendium of Audit Recipes for Continuous Quality Improvement in Anaesthesia*' - (2012)
- NICE Specialist Neonatal Care Quality Standards (2010)

2. Scope

2.1 Aims and objectives of service

The overall aim of the neonatal surgical service is to provide safe, high quality

surgery and anaesthesia to babies in line with national standards, which is delivered within the local neonatal network as close to home as possible. The neonatal surgery will be provided as part of the overall perinatal/neonatal pathway of care for the baby and will be delivered as part of a multi-disciplinary approach.

Objectives:

- To deliver neonatal surgery, anaesthesia and pain relief services which meet agreed local network and national standards and ensure that services are regularly assessed against them
- To provide neonatal surgery as close to the patient's home as possible, within the mother's booked network of care
- To ensure that the mother/families of babies diagnosed antenatally with a condition requiring surgery have the appropriate counselling and support provided
- To ensure that surgeons/anaesthetists are included in antenatal/neonatal multi-disciplinary meetings to ensure robust holistic decision-making
- Incorporate mechanisms to avoid complications and monitor evidence of improved learning/practice as a consequence of incidents e.g. pre-operative review of surgical and radiological cases and morbidity and mortality meetings
- To provide surgery and anaesthesia in an environment which is suitable for the age of the patient

2.2 Service description/care pathway

Neonatal surgery will be provided by surgeons and anaesthetists who have the appropriate training accredited by the Joint Committee on Surgical Training. Similarly the service will be led at all times by consultants who regularly anaesthetise babies/children and at all times there will be adequate, skilled assistance by trained staff. Children's surgeons/anaesthetists must demonstrate continued professional development relevant to neonatal surgery. Medical care needs will be provided by access to neonatologists or, where services are not co-located, by regular support from neonatologists (e.g. daily ward rounds)

Service Elements

Antenatally diagnosed conditions

For simple surgical conditions e.g. duodenal atresia >34 weeks gestation, a booked delivery in a NICU is not necessary, however a mother may wish to choose this.

For complex surgical conditions, e.g. gastroschisis, diaphragmatic hernia a booked delivery in the NICU will be required.

Shared obstetrics care will be in place with the local unit in both scenarios.

Pathway

- Surgical assessment by perinatal team at a NICU including input from geneticist, fetal medicine specialists and neonatologist/neonatal nurses
- The surgical team will ensure that parents receive appropriate information about the procedure, risks etc. Consent will be taken by surgeons who are fully conversant with the operation to be performed. Consent must be documented in all cases.
- Transfer for surgery will be arranged by the neonatal transfer team (where necessary) and surgery performed by a paediatric surgeon in the designated centre.
- Immediate post-operative care will be provided on the NICU jointly with the surgeon and anaesthetist and include acute pain services.
- On-going care and preparation for home/repatriation to local neonatal unit (LNU) or special care unit (SCU) provided by NICU
- Surgeons must be part of any conversations with parents following a death post-surgery.
- Appropriate transfer back to the appropriate LNU or SCU once clinically indicated. Decisions regarding transfer back to the local unit or home will be taken jointly by the neonatal and children's surgical team and the local neonatal and paediatric teams (acute and community) providing on-going care following repatriation or discharge home.
- Some babies will not require transfer back to the local neonatal or paediatric services and may be discharged home following liaison with the local neonatal and paediatric teams (acute and community) to ensure on-going care needs are identified and met.
- Follow up in surgical clinic as appropriate (surgical follow up may be delivered on an out-reach basis).
- Monitoring of two year neonatal outcomes as per the NICE care quality standard.
- Postnatally diagnosed conditions; acquired postnatal complications requiring surgery in pre-term and *term babies

Pathway

Diagnose and stabilise baby in local neonatal/special care unit with input from the surgeons and neonatologists in the NICU and the neonatal/paediatric transport team where appropriate.

- **1a.** If immediate surgery is not indicated, but there is a need for regular surgical review, the baby will be transferred to the NICU for medical management and regular surgical review.
- **1b.** If regular surgical review is not indicated the baby will be managed in the LNU or SCU unit, according to unit designation/clinical thresholds.

Transfer will be arranged by the appropriate neonatal/paediatric transfer service to the designated surgical centre.

Surgery performed by children's surgeons in the designated surgical center

- Immediate post-operative care will be provided on the NICU jointly by children's surgeon and neonatologist.
- Appropriate transfer back to the appropriate LNU or SCU once clinically indicated. Decisions regarding transfer back to the local unit or home will be neonatal and paediatric teams (acute and community) providing on-going care following repatriation or discharge home.
- Follow-up in surgical clinical as appropriate (surgical follow-up may be delivered on an out-reach basis)
- Some babies will not require transfer back to the local neonatal or paediatric services and may be discharged home following liaison with the local neonatal and paediatric teams (acute and community) to ensure on-going care needs are identified and met.
- Follow-up in surgical clinics as appropriate (surgical follow-up may be delivered on an out-reach basis)
- Monitoring of two year neonatal outcomes as per the NICE care quality standard.

*There may be a cohort of babies who are not diagnosed antenatally but who require surgery following acquired postnatal complications. In most cases these babies are assessed by a neonatologist and neonatal surgeon for surgery, but in stand-alone neonatal surgical units referrals may go directly to the paediatric surgery service.

For all babies, access to palliative care and bereavement support may need to start at any point in the pathway e.g. pregnancy, delivery room, neonatal unit, and/or home.

The multi-disciplinary team

The neonatal surgical episode will be supported as required by a wide range of professionals, the multi-disciplinary team (MDT) will include: the surgeon, paediatric anaesthetist, neonatologist, foetal medicine specialists, geneticists, neonatal transfer specialists, paediatric radiologist and pathologist, neonatal nurses paediatric specialist pharmacy, specialist laboratory support, specialist neonatal/paediatric dieticians, physiotherapists, speech and language therapists, occupational therapist, play specialists, lactation consultants and clinical psychologists, bereavements counsellors, counsellors, chaplains. (This is not an exhaustive list)
Specialised children's surgeons/anaesthetists will be included in the core membership in all neonatal/antenatal MDTs where surgery may be indicated.

Services will provide interpreter services as required for patients whose first language is not English.

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).

This specification includes all neonatal surgery. A neonate is normally defined as being 44 weeks post-menstrual age. For the purpose of surgery in babies, the period is extended to 60 weeks post conceptual age, because of the particular anaesthetic risks in this population and the requirement for specialist paediatric anaesthetists. Babies who lie outside this age group, or who are discharged from the neonatal services and subsequently need surgery, will be covered by the Specialised Children's Surgery/Anaesthetic and Acute Pain Service Specification.

The specification includes all the surgical sub-specialties i.e. paediatric general surgery, urology, orthopaedics, plastic surgery, neurosurgery, ophthalmic surgery, maxillofacial surgery, ENT. Because of the level of complexity of many congenital conditions, more than one speciality is often involved in any given patient's care.

*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 patient resident in Wales who are registered with a GP practice in England.

2.4 Any acceptance and exclusion criteria

Acceptance Criteria

Referrals will be accepted from any neonatal unit, including referrals from neonatal centres outside of the local neonatal network boundary, providing the referral has been discussed and agreed by the neonatal intensive care unit and paediatric surgery service.

Criteria for Referral

Referrals for neonatal surgery in pre-term babies must have been assessed by the perinatal/neonatal team at the NICU. Referrals for term babies may or may not require assessment by neonatology where a stand-alone neonatal surgical unit is in place, however all such referrals must be regularly reviewed by the neonatal team during admission. Guidelines must be in place to ensure regular neonatal MDT review of all surgical babies in both stand-alone and co-located neonatal surgical

units.

Exclusions

Surgery on children/babies who have been discharged from the neonatal service will be treated as paediatric patients and the relevant paediatric service specification will apply.

2.5 Interdependencies with other services

The neonatal surgical service is dependent upon joint working with the neonatal unit services, in all levels of neonatal services, including neonatal transfer services, and with obstetric, perinatal and foetal medicine specialists addressing the needs of family-centred care, appropriate to the babies' condition.

Services will require availability of a 24/7 neonatal/paediatric transfer service which enables the safe transfer of babies when transfer is necessary.

Services will have appropriate paediatric radiology cover which operates on a 24/7 basis. This may be as part of a network arrangement with other units, but where this is the case, there must be clear processes and pathways in place. Where 24/7 cover is not in place within the trust, or as part of a network arrangement, providers will ensure that they have systems in place which mitigate the risk for patients.

Pain management is an integral component of neonatal surgery and providers will ensure that they have an appropriate acute pain service for babies/children with a clear policy for advice about management of pain. All babies will have an appropriate pain management assessment and multi-modal analgesia management plan. The service will have the capability to safely provide epidural and opiate infusions for babies. All analgesia for babies must be prescribed and administered by registered and appropriately trained personnel.

Histopathological examination of biopsies of tissues and organs removed at operation is essential for accurate diagnosis. Selection of the best treatment for the baby often depends on histological findings, for example Hirschsprung's disease, one cause of neonatal bowel obstruction. Specialist paediatric histopathologists should be involved with the pathological diagnosis of neonatal/paediatric surgical specimens. All specimens on babies should ideally be reported by specialist paediatric pathologists in a specialist centre. Access to expertise in specific tumour site pathology should be available for the diagnosis of tumours in young people.

Furthermore, '*Commissioning Safe and Sustainable Specialised Paediatric Services*' (Department of Health, 2008) describes the required interdependencies between paediatric services in order to ensure safe practice. In line with the Department of Health's '*Safe & Sustainable Specialised Paediatric Service Framework*' (August 2008), neonatal services will have robust pathways in place to the specialties

indicated below

Amber interdependencies require a pathway to other specialties be in place, according to the timescales provided in the table below. These interdependent specialties do not necessarily have to be co-located. Providers shall demonstrate robust pathway arrangements as per the requirements stipulated below:

Speciality	Timescales/Arrangements
Specialised Paediatric Surgery	An integrated clinical service; visit by consultant paediatric specialist, or transfer of care. Time-scale: available within four hours
Cardiology	Visit by consultant specialist, or transfer of care. Time-scale: next working day
Specialised Paediatric Anaesthesia	Planned intervention Timescale: As required

(‘Commissioning Safe and Sustainable Specialised Paediatric Services’ – Department of Health, August 2008)

Ideally, the neonatal surgical centre will be co-located with the specialist surgical service and NICU. In addition, neonatal surgical teams will need to have in place robust referral pathways to the following specialties to ensure that patients with ongoing needs are referred appropriately to the associated paediatric specialty, which include: paediatric: neurosurgery, endocrinology, plastic surgery, nephrology, cardiology, oncology, gastroenterology and respiratory.

3. Applicable Service Standards

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

Location

Neonatal surgery services should take place on the same hospital site as the paediatric surgical/anaesthetic service and be co-located with the NICU specialised paediatric and maternity services.

Prenatal Surgical Support

Surgical support must be available for families where a surgical condition is suspected antenatally, including specialist counselling and/or senior nurses; information leaflets; the opportunity to visit the surgical centre antenatally; and ongoing prenatal advice as required.

Nominated consultant Paediatric Surgeon

A nominated lead consultant paediatric surgeon must be responsible for the direction and management of the neonatal surgery service.

Nursing Staff

All nursing staff providing pre and post-operative care for pre-term babies will have up to date expertise in the care of the pre-term baby. Staffing levels and competencies should be in line with principles 2 and 5 of the Neonatal Toolkit.

Dietetic Care

A dietician with expertise in the care of babies needing surgery is available to support the neonatal surgical service.

On Call

A consultant surgeon (neonatal), consultant specialist paediatric anaesthetist and neonatologist should be on call for the neonatal service at all times.

Anaesthesia

Units providing neonatal surgery have a consultant anaesthetist designated to provide anaesthesia for new-born babies available at all times. Each of these consultant specialist anaesthetists must have appropriate higher and advanced training, and regular involvement in emergency and elective neonatal surgery.

Surgical Out-Reach

The neonatal surgery service should have a written agreement with each of its referring centre for out-reach clinics.

Infection Control

The provider will ensure that patients recover appropriately following surgery and that infection is minimised and managed according to the trust's infection control policy. The trust will evidence compliance against the policy, including infection control audits. (NHS Outcomes Framework – Domain 3)

Safeguarding

All clinical staff involved in neonatal surgery must have level 3 safeguard training (as per the intercollegiate standards). Training must be updated annually.

(Safeguarding children and young people-roles and competencies for health care staff. Intercollegiate document, September 2010. www.rcpch.ac.uk/safeguarding)

Protecting children and young people: responsibilities of all doctors. GMC Sept 2012.
www.gmc-uk.org/guidance)

Paediatric Life Support

Paediatric surgical nursing staff surgeons and anaesthetists will have appropriate advanced life support training which is updated annually.

Clinical Records Bureau (CRB) Checks

Providers will ensure that all staff involved in neonatal surgery will have undergone an enhanced CRB check.

Environment

Dedicated children's facilities will be available in operating theatres and recovery areas.

Access to Theatres

Services will have ready access to appropriate operating theatres, and emergency theatre access will be available at all times in all neonatal surgical centres.

Equipment

All staff using paediatric/neonatal surgical equipment must receive appropriate training. A full range of appropriately maintained paediatric equipment, of the correct size and design for the child/baby, including resuscitation equipment, must be available.

Paediatric resuscitation equipment must be available wherever and whenever children are treated.

Patient/Carer Participation and Voice

In line with the NHS Outcomes Framework (2012/13 - Domain 4 – Ensuring that people have a positive experience of care) providers will undertake a children and parent experience survey and be able to demonstrate continuous improvement using feedback received.

4. Key Service Outcomes

Services will be required to provide data on the following outcome indicators:

- Number of cancelled operations leading to avoidable delay and negative patient experience
- 28 day re-admission rates
- Number of unplanned admissions to paediatric intensive care unit (PICU)
Number of serious untoward incidents (SUIs) reported
- Number of written complaints received Infection monitoring as per section 3.1
- Mortality and morbidity meetings – (twice yearly specifically for surgical neonatal cases) demonstrating evidence of improved learning and multi- disciplinary review
- An audit programme of all surgical activity covering pre and post-operative management, pain management, outcomes of care, peri-operative deaths and major complications, including deaths following discharge from hospital
- Patient experience survey

ANNEX 1 TO SERVICE SPECIFICATION:

PROVISION OF SERVICES TO CHILDREN

Aims and objectives of service

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

The generic aspects of care: The Care of Children in Hospital (Health Service Circular (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 minimise 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 Interdependencies*’ – Department of Health

Imaging

All services will be supported by a three-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.
- All radiologists, and radiographers will have appropriate training, supervision and access to continuing professional development
- All equipment will be optimised for paediatric use and use specific paediatric software

Specialist Paediatric Anaesthesia

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 neurosciences 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
2. Certificates 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,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 person's care except where this is not in the best interests of the child / young person and in the case of young people who have the capacity to make their own decisions is subject to their consent.
- Parents/carers who wish to stay overnight are provided with accessible accommodation unless there are safeguarding concerns or this is not in the best interests of the child/ young person.

Applicable national standards e.g. NICE, Royal Colleges

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 two 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 which 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.

- Participating in local safeguarding children boards where required and understand their responsibilities and the responsibilities of others in line with the Children Act 2004.
- Having clear procedures followed in practice, monitored and reviewed in place about the use of restraint and safeguarding.
- Taking into account relevant guidance set out in the Care Quality Commission's Schedule of Applicable Publications
- Ensuring that those working with children must wait for a full CRB disclosure before starting work.
- training and supervising staff in safeguarding to ensure they can demonstrate the competences listed in Outcome 7E of the *Essential Standards of Quality and Safety*, Care Quality Commission, London 2010

All children and young people who use services must be

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

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

Key Service Outcomes

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

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

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

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

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

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

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

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

All paediatric patients should have access to appropriately trained paediatric trained dietitians, 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 Publications, 2006, London