D06/S/a

NHS STANDARD CONTRACT

FOR SPECIALISED BURNS CARE (ALL AGES)

SCHEDULE 2 – THE SERVICES A. SERVICE SPECIFICATIONS

Service Specification No.	D06/S/a
Service	Specialised Burn Care (All Ages)
Commissioner Lead	
Provider Lead	
Period	12 months
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

National Context

The complexity and rarity of burn injuries makes delivering burn care a specialised service.

Although significant advances have been made in burn care over recent decades, it is recognised that to achieve the best possible clinical outcome for burn injured patients, burn care must be delivered by expert multi-disciplinary teams in specialised burn services.

Formal standardised processes, structures and agreed working practices are required to continue improving the survival rates and quality of life for patients who have sustained a burn injury [4].

Patients with burn injuries often present with unique clinical, psychological and social challenges; burn injury can be one of the most severe forms of trauma and therefore treatment in specialised services is required.

Burn care services and burn care networks have developed organisational processes to meet the complex needs of these patients while at the same time ensuring care is delivered close to home as soon as possible.

Approximately 130,000 people with burn injuries visit Emergency Departments (ED) each year [6] and approximately 10,000 are admitted to hospital [6]. Of these, approximately 500 are admitted to hospital with severe burn injuries which require fluid-resuscitation [22]. Approximately half of these are children under 16 years of age [22]. The majority of cases referred to specialised burn services will fall towards the lower end of the severity spectrum. It must be remembered that such injuries require specialised care to achieve good outcomes, reduce long-term scarring and prevent other on- going problems.

Specialised burn services focus on the management of people with burns which require referral to and assessment by, a specialised burn service (in line with agreed National Referral Guidance [23]). Burn care activity is predominantly driven by emergency admissions (although there are a small number of elective cases for reconstructive surgery). The specialised care pathway (see Appendix A) involves immediate assessment and treatment, acute care, rehabilitation, surgical reconstruction and on-going community care to maximise recovery.

In England and Wales burn care is organised using a tiered model of care [22] whereby the most severely injured are cared for in services recognised as Centres and those requiring less intensive clinical support being cared for in either a Unit or a Facility. This provides a balance between easy access and care provided closer to home for the majority of patients with highly specialised, centralised services for a much smaller proportion of patients with more severe injuries.

The report of the National Burn Review Committee (2001) [22] has defined national policy in this area since its publication.

Aetiology and Epidemiology of Burn Injuries

Burn injuries are largely non-intentional, caused by carelessness or inattention, pre-existing medical conditions (the presentation of which may be a collapse), or they may follow alcohol or drug abuse [7]. The most common location for burn injuries is the home and the most common cause of burn injury are scalds from hot drinks. The cohorts of patients at greatest risk of sustaining a burn injury are those in the lowest socio-economic groups. The most vulnerable groups in society are at greatest risk of having an accidental injury. Children and young men are more likely to suffer a burn injury than other age groups. Social deprivation and population density are closely associated with the prevalence and incidence of burns [8-12]. According to the World Health Organisation, burn injuries occur disproportionately among racial and ethnic minorities as their often low socio-economic status increases the likelihood of people in these groups sustaining a burn injury [11].

There are an increasing number of older adults sustaining burn injuries because of the current trend associated with the ageing population [13]. There is a clinical consensus that older adults with burn injuries are complex to treat and are likely to have a prolonged length of hospital stay. For adult patients with burn injuries there is a strong positive correlation between age and mortality [14, 15]. People with burn injuries have an increased likelihood of having pre-injury mental health issues as compared with the general population [16, 17].

A burn injury can have a variety of aetiologies such as thermal (flash, contact, scald, radiation), electrical (low voltage, high voltage) and chemical (acid, alkali) [18].

There are also a number of rare skin-loss conditions which can cause massive burn-like wounds and symptoms which may best be treated within a specialised burn service [19, 20].

The severity of a burn is dependent on the size and anatomical site of the injury, the depth of the burn, the age of the patient, the presence of an inhalation injury and other significant co-morbidities. All of these factors will influence morbidity and mortality. The severity of a burn is usually described in terms of depth and percentage total body surface area (%TBSA). Initial assessment and management by professionals with experience in burn care and experience and training in acute burn management will reduce the risk of potentially life or limb threatening conditions not being recognised [7].

Burn injuries can have a significant, sustained and profound physical, psychological and social effect on the patient, family and carers. The physical damage to tissue and the physiological effect caused by the agents involved will affect the function and appearance of the tissue and limbs. This coupled with the psychological effects of having had a burn injury can also influence the psychological and social wellbeing of the patient. The physical and psychological consequence of a burn injury are not always dependent on the severity or site of the injury.

Infection is a major complication of burn injury. Infection is linked to impaired resistance from disruption of the skin's mechanical integrity and generalised immune suppression. “Stewardship” of antibiotic antiseptic use to reduce infection risk is therefore paramount.

Key factors (relating to treatment) that impact on burn outcomes include early fluid resuscitation, prompt wound care, and timely access to effective surgical and therapeutic management (including surgical excision).

Evidence Base

MTG2: MoorLDI2-BI: a laser doppler blood flow imager for burn wound assessment

http://publications.nice.org.uk/moorldi2-bi-a-laser-doppler-blood-flow-imager-for-burn-wound-assessment-mtg2

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators (Appendix 1)

Domain 1	**Preventing people from dying prematurely**	✓
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	✓
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

The service will complete/update the nationally agreed Quality Dashboard for specialised burn care services. For 2013/14 these outcome measures relate to:

- IBID Data Completeness
- Compliance with National Referral Guidance
- Surgical Management - Assessment of resus burns by a burns consultant within 12 hours of admission
- Adequate Analgesia given
- Timely Healing
- Optimising psychological well-being
- Optimising Functional Outcome

3. Scope

3.1 Aims and objectives of service

Specialised burn care services aim to reduce mortality and optimise both

physical and psychological outcomes following burn injury.

The above aim will be achieved by:

- Delivering treatment and care that conforms to national standards and published clinical guidelines
- Being responsive to the psychological needs of patients and their families
- Delivering care holistically, ensuring that all patients have access to a wide range of specialist multi-disciplinary services
- Encouraging an environment in which patients and families are able to make informed decisions about their treatment
- Facilitating on-going care as near to the patient's own community where clinically appropriate
- Delivering the appropriate elements of specialist burn care treatment as part of a recognised managed clinical network
- Ensuring equity of access to specialised burn care for adults and children
- Responding effectively to major incidents involving a significant number of burn casualties [3]

3.2 Service description/care pathway

Service Delivery

Specialised burn care services provide:

- assessment
- acute care (including actual care and surgical care)
- rehabilitation
- surgical reconstruction
- on-going follow-up care

To patients with burn injuries that are too complex or severe to be appropriately cared for by community services or District General Hospitals.

In England and Wales specialised burn care is organised using a tiered model of care (Centre, Unit and Facility) whereby the most severely injured are cared for in services recognised as Centres, those requiring less intensive clinical support are cared for in services recognised as Units, and those with non- complex burn injuries can be cared for in services recognised as facilities. The aim of the tiered model is to utilise resource and expertise optimally. A burn care service at a given level will also provide a 'lower' level service to its local population (for example an adult Burn Centre will also provide an adult Unit and Facility level service).

- **Burn Facilities** provide acute care for people with less complex burns (in line with National Burn Care Referral Guidance). These services form part of a plastic surgery service. Burn Facilities refer patients to Burn Units and Centres for the treatment of more complex injuries (in line with national and local threshold guidance). Burn Facilities are an integral part of the patient pathway in the provision of a rehabilitation service for patients from their local area who have

more complex injuries.

- **Burn Units** provide care for patients with a burn of moderate size and/or moderate severity (in line with National Burn Care Referral Guidance). These services treat patients across a wider area than Burn Facilities and provide treatment for patients requiring critical care (such as care in a high dependency unit).
- **Burn Centres** provide care for patients with the most severe injuries and for those requiring the highest level of critical care (in line with National Burn Care Referral Guidance).

A summary of the core requirements for the delivery of specialised burn services at each level are described in section 4.1.

Adults and children with burn injuries are referred to specialised burn services from a number of different sources; NHS walk-in centres, general practitioners, emergency departments, minor injuries units, community health services, other acute hospital services or by the patient themselves.

There are a number of factors that will influence the need for a patient to be referred to a specialised burn service. These include the size, type and severity of the burn itself, the age of the patient and any co-morbidity.

The threshold for referral to specialised burn services is based on age and severity of the injury. The initial indication for referral to a specialised burns service is outlined within the National Network for Burn Care's National Burn Care Referral Guidance [23].

The latest version of this guidance is attached as Appendix B.

Resources

All the necessary resources available as per the National Burns Care Standards 2013 are detailed below:

Burn Centre

Specialised Burn Centres (BC) provide care for patients with the most complex injuries. Services providing Centre level care would treat patients with the most severe and complex injuries – including those that require the highest levels of critical care.

Facilities and equipment (Burn Centres)

Burn Centres will provide the following on the same hospital site as the service:

- A physically separate ward specifically for the care of adult burn patients or children, never both
- Access to a temperature controlled operating theatre within close proximity (approximately <50 metres) of the critical care service for burn patients
- Single bedded thermally controlled cubicles to care for burn injured patients

(when clinically required)

Supporting Services (Burn Centre)

Critical Care Service

Burn Centres will provide appropriately staffed critical care meeting the following requirements:

- **Adults**: A service providing levels 3 and 2 intensive care located on the same hospital site as the service
- **Paediatrics**: A Paediatric Intensive Care Unit and a Paediatric High Dependency Unit both of which must comply with the relevant Standards for the Care of Critically Ill Children – Paediatric Intensive Care (Paediatric Intensive Care Society, 2010) located on the same hospital site as the service.
- **Neonates**: Burn Centres admitting preterm babies should be located on the same hospital site as a neonatal intensive care unit.

On Site Support Services

(In addition to those listed above) Burn Centres will be co-located with or have on-site access to the following services:

- Emergency Department (age appropriate)
- Trauma Unit (age appropriate – see note below)
- Dedicated Anaesthetists experienced in Burn Care (age appropriate)
- Pain Service (age appropriate)
- General medicine or Paediatric Medicine
- General surgery or Paediatric Surgery
- Orthopaedic Surgery
- Care of the Elderly (relevant to adult Burn Care Centres only)
- 24/7 Radiology (including computed tomography **(**CT) Scanning, Magnetic resonance imaging
- (MRI), ultrasound and doppler tests)
- 24/7 Pathology services
- 24/7 Transfusion services
- Respiratory physiotherapy service
- Infection prevention and control

Trauma Care

It is considered optimal for an adult or paediatric Burn Care Centre to be co- located with a corresponding adult or paediatric major trauma centre. Where this is not the case, mechanisms for ensuring appropriate integration with trauma centre care will be in place.

Access as required to

Burn Centres should have access as required to the following:

- Ophthalmology (age appropriate)
- Renal Medicine (age appropriate)
- Ear Nose and Throat (ENT) (age appropriate)
- Maxillofacial (age appropriate)
- Mental health services (age appropriate)
- Neurosurgery (age appropriate)
- Cardiothoracic Surgery (age appropriate)
- Microbiology Service (access to tests and results without delay)
- Neurology
- Speech & language therapy
- Medical illustration/photography
- Skin camouflage service
- Medical tattooing service
- Prosthetic service

Staffing (Burn Centre)

An adult or paediatric Burn Care Centre will have:

- Burn specific consultant led clinical care available 24 hours a day, 7 days per week. This rota should be legal and sustainable (See national burn care standards for more details)
- At least one ST3 or above (or equivalent) doctor who has completed initial stage training in plastic surgery available at all times

A Paediatric Centre will meet the applicable **Paediatric Intensive Care Society** (PICS) standards in relation to in- patient services including:

- 24 hour cover by a consultant Paediatrician who is able to attend within 30 minutes and does not have responsibilities to other hospital sites (PICS Std 14)
- A clinician with competences in resuscitation, stabilisation and intubation of children should be available on site at all times (PICS std 16 & 34)
- 24 Hour resident cover by a clinician trained to, or training at, the equivalent of paediatric medicine (Royal College of Paediatrics and Child Health (RCPCH)) level 2 competences or above (PICS Std 67).

Nursing

The nursing establishment will contain sufficient registered nurses to meet the recommendations contained within the National Burn Care Review (Appendix 3) [23] and national guidance relating to critical care (PICS Standards in relation to Paediatric Centres). The service must have the capability to adjust the skill mix and numbers of registered nurses to reflect the changes in complexity of the patients cared for in the service.

All registered nurses must have completed specific burn competencies and been

assessed as being competent in burn care by the end of their second year in the speciality.

Therapies

Staff from the following services will be members of the Burn Care Team and should be available for the time as stated below:

- Physiotherapy (seven days a week)
- Occupational Therapy (seven days a week)
- Dietetics (five days a week)
- Play (Paediatric Services Only - seven days a week)

Psychological Care

Health professionals will be available to provide levels 3-5 of the tiered model of Psychological care to burn injured patients (as described within the National Burn Care Standards [23]). This includes on-going assessment and monitoring of psychological status and delivery of psychological interventions when needed for patients and families.

Rehabilitation

The service must have access to specialised rehabilitation care. The rehabilitation facilities should be available to both in-patients and out-patients.

Outreach

The service must provide an integrated nursing and therapy service which can facilitate the delivery of specialised burn care and advice to patients, their families and /or carers in an area other than the acute hospital environment providing specialised burn care.

Guidelines and protocols (Burn Centres)

The service will work to a comprehensive set of guidelines and protocols (as outlined in the relevant section of the National Burn Care Standards [23]). Where nationally agreed guidelines exist these should be adopted. Clinical guidelines will follow the latest National Institute for Health and Clinical Excellence (NICE) guidance wherever relevant and be informed by the latest evidence of effectiveness.

Governance (Burn Centres)

The service will form part of the agreed national/network configuration of burn care services.

The service should work towards compliance with all National Burn Care Standards and undertake regular self-assessment and peer review assessment against these.

The service will actively participate in the work of the Burn Care Network, including attendance at network meetings, supporting network-wide training and development, research and clinical review.

Burn Unit

Specialised Burn Units (BU's) provide care for patients with a burn of moderate size and/or moderate complexity. These services will treat patients across a wider area than burn facilities and provide treatment for patients with moderately severe injuries requiring critical care, such as care in a high dependency unit.

Facilities and equipment (Burn Units)

Burn Units will provide the following on the same hospital site as the service:

- A physically separate ward specifically for the care of adult burn patients or children, never both
- Access to a temperature controlled operating theatre within close proximity (approximately <50 metres) of the critical care service for burn patients
- Single bedded thermally controlled cubicles to care for burn injured patients (when clinically required)

Supporting Services (Burn Units)

Critical Care Service

Burn Units will provide appropriately staffed critical care meeting the following requirements:

- **Adults**: A general intensive care unit on the same hospital site as the Burn Unit. A service providing level 2 intensive care located on the same hospital site as the service.
  Paediatrics: On-site high dependency care 24 hours a day, 7 days per week. Any child requiring ventilation for more than 24 hours must be managed within a PICU. Therefore there should be agreed systems in place for the transfer of children to a PICU if they require ventilation for more than 24 hours.

On Site Support Services

(In addition to those listed above) Burn Units will be co-located with or have on-site access to the following services

- Emergency Department (age appropriate)
- Trauma Unit (age appropriate)
- Dedicated Anaesthetists experienced in Burn Care (age appropriate)
- Pain Service (age appropriate)
- General medicine or Paediatric Medicine
- General surgery or Paediatric Surgery
- Orthopaedic Surgery

- Care of the Elderly (relevant to adult Burn Care Centres only)
- 24/7 Radiology (including CT Scanning, MRI, ultrasound and doppler tests)
- 24/7 Pathology services
- 24/7 Transfusion services
- Respiratory physiotherapy service
- Infection prevention and control

Access as required to

Burn Units will have access as required to the following:

- Microbiology service (access to tests and results without delay)
- Ophthalmology (age appropriate)
- Renal Medicine (age appropriate)
- ENT (age appropriate)
- Maxillofacial (age appropriate)
- Mental health services (age appropriate)
- Neurosurgery (age appropriate)
- Cardiothoracic Surgery (age appropriate)
- Neurology
- Speech and language therapy
- Medical illustration / photography
- Skin camouflage service
- Prosthetic service

Staffing (Burn Units)

An adult or Paediatric Burn Care Unit will have:

- Access to consultant burn care 5 days per week during the working day. The provision of consultant led burn care must be supplemented by sufficient consultant plastic surgeons to provide consultant led care on a 24 hours a day, 7 days per week basis
- At least one ST3 or above (or equivalent) doctor who has completed initial stage training in plastic surgery should be available at all times

A paediatric unit will meet the applicable PICS standards in relation to in- patients services including:

- 24 hour cover by a consultant paediatrician who is able to attend within 30 minutes and does not have responsibilities to other hospital sites (PICS Std 14)
- A clinician with competences in resuscitation, stabilisation and intubation of children should be available on site at all times (PICS std 16 & 34)
- 24 hour resident cover by a clinician trained to, or training at, the equivalent of paediatric medicine (RCPCH) level 2 competences or above (PICS Std 67)

Nursing

The nursing establishment will contain sufficient registered nurses to meet the recommendations contained within the National Burn Care Review [23] and national guidance relating to critical care (PICS Standards in relation to Paediatric Centres). The service must have the capability to adjust the skill mix and numbers of registered nurses to reflect the changes in complexity of the patients cared for in the service.

All registered nurses must have completed specific burn competencies and been assessed as being competent in burn care by the end of their second year in the speciality.

Therapies

Staff from the following services will be members of the Burn Care Team and should be available as stated below:

- Physiotherapy (seven days a week)
- Occupational Therapy (seven days a week)
- Dietetics (five days a week)
- Play (Paediatric Services Only - seven days a week)

Psychological Care

Health professionals will be available to provide levels 3-5 of the tiered model of psychological care to burn injured patients (as described within the National Burn Care Standards [23]). This includes on-going assessment and monitoring of psychological status and delivery of psychological interventions when needed for patients and families.

Rehabilitation

The service must have access to specialised rehabilitation care. The rehabilitation facilities should be available to both in-patients and out-patients.

Outreach

The service must provide an integrated nursing and therapy service which can facilitate the delivery of specialised burn care and advice to patients, their families and /or carers in an area other than the acute hospital environment providing specialised burn care.

Guidelines and protocols (Burn Units)

The service will work to a comprehensive set of guidelines and protocols (as outlined in the relevant section of the National Burn Care Standards). Where nationally agreed guidelines exist these will be adopted. Clinical guidelines will follow the latest NICE guidance wherever relevant and be informed by the latest evidence of effectiveness.

Governance (Burn Units)

The service will form part of the agreed national/network configuration of Burn Care Services.

The service will work towards compliance with all National Burn Care Standards and undertake regular self-assessment and peer review assessment against these.

The service will actively participate in the work of the Burn Care Network, including attendance at Network meetings, supporting network-wide training and development, research and clinical review.

Burn Facility

Specialised Burn Facilities (BF) provide acute care for people with non- complex burns. The service is an integral part of a plastic surgery service. Burn Facilities refer patients to Burn Units and Centres for the treatment of complex injuries. Burn Facilities are an integral part of the patient pathway in
the provision of a rehabilitation service for complex burns from their local area.

Facilities and equipment (Burn Facilities)

Burn Facilities will provide the following on the same hospital site as the service:

- Burn care beds available in a shared environment with plastic surgery, trauma (or in the case of paediatric burn facilities – paediatric services)
- Access to an Operating Theatre

Supporting Services (Burn Facilities)

On Site Support Services

(In addition to those listed above) Burn Facilities will be co-located with or have on-site access to the following services:

- Pain Service (age appropriate)
- General medicine or Paediatric Medicine

- General surgery or General paediatric surgery
- Care of the Elderly (relevant to adult Burn Care Centres only)
- Radiology
- Pathology services
- Transfusion services
- Respiratory physiotherapy service
- Infection prevention and control

Access as required to

Burn Facilities will have access as required to the following:

- Microbiology service
- Ophthalmology (age appropriate)
- Renal Medicine (age appropriate)
- ENT (age appropriate)
- Maxillofacial (age appropriate)
- Mental health services (age appropriate)
- Neurosurgery (age appropriate)
- Cardiothoracic Surgery (age appropriate)
- Orthopaedics (age appropriate)
- Neurology
- Speech and language therapy
- Medical illustration / photography
- Renal medicine
- Cosmetic camouflage service
- Medical tattooing service
- Prosthetic service

Staffing (Burn Facilities)

An Adult or Paediatric Burn Care Facility will have:

- A consultant plastic surgeon available 24 hours / 7 days per week. At least one consultant plastic surgeon should have a significant interest in burn care and be formally nominated as the lead for burn care.
- At least one ST3 or above (or equivalent) doctor who has completed initial stage training in plastic surgery should be available at all times

A Paediatric Facility will meet the applicable PICS standards in relation to in- patient services including:

- 24 hour cover by a consultant paediatrician who is able to attend within 30 minutes and does not have responsibilities to other hospital sites (PICS Std 14)
- A clinician with competences in resuscitation, stabilisation and intubation of children should be available on site at all times (PICS std 16 & 34)
- 24 Hour resident cover by a clinician trained to, or training at, the equivalent of paediatric medicine (RCPCH) level 2 competences or above (PICS Std 67)

Nursing

The nursing establishment will contain sufficient registered nurses to meet the recommendations contained within the National Burn Care Review [23] and national guidance relating to critical care (PICS Standards in relation to Paediatric Centres). The service must have the capability to adjust the skill mix and numbers of registered nurses to reflect the changes in complexity of the patients cared for in the service.

Therapies

Staff from the following services will be members of the burn care team and should be available as stated below:

- Physiotherapy (seven days a week)
- Occupational Therapy (seven days a week)
- Dietetics (five days a week)
- Play (Paediatric Services Only - seven days a week)

Psychological Care

Health professionals will be available to provide levels 3-5 of the tiered model of psychological care to burn injured patients (as described within the National Burn Care Standards). This includes on-going assessment and monitoring of psychological status and delivery of psychological interventions when needed for patients and families.

Guidelines and protocols (Burn Facilities)

The service will work to a comprehensive set of Guidelines and Protocols (as outlined in the relevant section of the National Burn Care Standards). Where nationally agreed guidelines exist these should be adopted. Clinical Guidelines should follow the latest NICE guidance wherever relevant and be informed by the latest evidence of effectiveness.

Governance (Burn Facilities)

The service will form part of the agreed national/network configuration of Burn Care Services.

The service will work towards compliance with all National Burn Care Standards and undertake regular self-assessment and peer review assessment against these.

The service will actively participate in the work of the Burn Care Network, including attendance at Network Meetings, supporting network-wide training and development, research and clinical review.

The Specialised Burn Care Pathway

Referral

Adults and children with burn injuries are referred to specialised burn services from a number of different sources; NHS walk-in centres, general practitioners, emergency departments, minor injuries units, community health services, other acute hospital services or by the patient themselves.

The threshold for referral to specialised burn services is based on age and severity of the injury. The initial indication for referral to a specialised burns service is outlined within the National Network for Burn Care's National Burn Care Referral Guidance [23].

Where burn injury occurs in isolation or alongside less serious injury then patients should be transported in accordance with local pre-hospital triage protocols. Ideally this would be to an Emergency Department associated with a Specialised Burn Service of the appropriate level. This would ensure that burns expertise is available on site and thus reduce the potential need for a secondary transfer. Where this is not possible, transfer to an appropriate specialised burn service should occur as early as possible after injury.

An overview of the specialised burn care pathway is shown as **Appendix 2**. In summary, the specialised burn care pathway will include:

Emergency Care
In-patient management of the acute burn by an extensive multi- disciplinary team focusing on intensive surgical care (including critical care if necessary), specialised nutritional care and therapy services, including physiotherapy, occupational therapy, psychology, speech and language therapy. The focus of the inpatient stay should be to ensure that patients are enabled to recover from their injuries as quickly as possible.

Discharge planning, Continuing Care and Rehabilitation (from the acute service).
Patients will remain at the specialised burn service in which they have received their care until it is appropriate for either initiation of discharge to commence or transfer to an appropriate specialised burn service (or non-specialised service such as a local hospital) closer to home.

Often, patients who have sustained a burn injury will require follow-up care, which can take place over a prolonged period of time. This can include: regular dressing changes, specialist therapy (for example physiotherapy, psychological care, and scar management) and specialist reconstruction. The development of specialised burns services at Facility level and the development of specialised outreach will play an integral part in providing high-quality, accessible services for the on-going care of patients following burn injury.

Service Locations Across the Pathway

Therefore, in delivering services across the specialised burn care pathway patients will be treated within:

- Intensive Care and High Dependency Units (including dedicated burn care Intensive Care and High Dependency Units);
- Burn wards/plastic surgery wards within Burn Centres, Units or Facilities;
- Out-patient and outreach clinics;
- At times it will be appropriate for patients to receive aspects of the specialised burn care pathway in settings away from the specialised burn care service – where there are appropriate outreach services in place.

The Burn Care Network

Specialised Burn Care Services will be delivered as part of a formal Burn Care Network. This ensures that individual patient care is coordinated as part of agreed care pathways. The benefits of delivery of specialised burn care services through a network of care are as follows:

- The right care, provided to the right patients, in the right places, at the right time, and at appropriate locations and levels
- Consistency in approach to and implementation of referrals, protocols, performance and quality audits and other tools

The Burn Care Network for specialised burn care will provide high quality care for all patients, from the point of admission to full recovery.

The Burn Care Network is comprised of Burn Centres, Units and Facilities delivering a tiered model of care (as described above).

Specialised Burn Care services, working as part of a Burn Care network, will work collaboratively with a range of other agencies including emergency departments and primary care services. The service model also includes delivery of specialised burn care remotely from the acute burn care setting – as part of an outreach service.

Specialised Commissioners will agree the configuration of burn care services for their population.

For each service, commissioners will agree:

- the type of service provided (Facility, Unit or Centre),
- burn thresholds for admission, the age of patients admitted (lower and upper limits),
- minimum activity,
- occupancy levels at which commissioners should be informed,
- location/s of out-patient and dressing clinics,
- the burn care network which the service is part of,
- Emergency Departments which will normally refer patients with burns to the service.

In establishing the service configuration for a given network it should also be recognised that there will inevitably be patient flows across network boundaries, particularly for patients who reside near Burn Network boundaries.

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)

Operational Delivery Network

There will be an Operational Delivery Network (ODN) expected for this service area, as outlined in the Service Specification for Burns ODNs. . ODNs will ensure quality standards and networked patient pathways are in place. They will focus on an operational role, supporting the activity of Provider Trusts in service delivery, improvement and delivery of a commissioned pathway, with a key focus on the quality and equity of access to service provision. This will allow for more local determination, innovation and efficiency across the pathway. ODNs support the delivery of 'Right Care' principles by incentivising a system to manage the right patient in the right place.

Communication

There will be effective communication between all those responsible for the patient's care, the patient and where appropriate their family and other carers.

Patients will be provided with a full range of condition-specific information in appropriate formats.

ODN for Burns Care will take an active role in supporting network-wide communication.

Audit, Governance and Quality Improvement

The services will form part of the agreed national/network configuration of Burn Care Services.

The services will work towards compliance with all National Burn Care Standards and undertake regular self-assessment and peer review assessment against these. The performance of units, including measures of effectiveness of care, compliance with guidelines and prevention of avoidable morbidity and mortality will be audited, benchmarked against national norms via the Burns Care Quality Dashboard and the results used to promote service development and improvements.

The services will actively participate in the work of the Burn Care Network, including attendance at Network Meetings, supporting network-wide training and development, research and clinical review.

The service will have a rolling programme of audit, including audit of: implementation of evidence based guidelines; referrals and transfer times (with results communicated to referring services); refused admissions and reasons for refusals; time to theatre for emergencies; key process and outcome measures. There should be a network audit of the care of all Centre level patients.

The service will submit the International Burn Injury Database (IBID) minimum dataset on all patients within expected timescales. All patients admitted with a burn injury or for

burn injury related care have their care and treatment recorded using the speciality code for burn care.

Centre and Unit level services will ensure daily update of the National Burn Bed Bureau web system (www.nbbb.org.uk).

Education and Training

There should be a competence framework and training plan for all the disciplines within the multidisciplinary team which details the competencies required to care for a burn injured patient as per the National Burns Care Standards (2013 B16, B17, B18).

3.3 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 General Practitioner (GP) Practice in Wales, but INCLUDES patients resident in Wales who are registered with a GP practice in England.

Specialist burn care services include all burn care delivered by Burn Centres, Burn Units and Burn Facilities delivered as part of a provider network. This covers the whole pathway including:

- Specialist assessment
- Admission to a Centre, Unit or Facility and
- Rehabilitation and surgical reconstruction

This applies to provision in adults and children.

3.4 Any acceptance and exclusion criteria and thresholds

Acceptance Criteria:

Adults and children with burn injuries are referred to specialised burn services from a number of different sources; NHS walk-in centres, general practitioners, emergency departments, minor injuries units, community health services, other acute hospital services or by the patient themselves.

- The service will accept referrals for patients who meet the relevant threshold for referral set out in the National Burn Care Referral Guidance [23]. The latest version of this guidance as included as appendix 2.

NHS England Clinical Commissioning policies and Statements

Exclusion Criteria:

Adults and children with a burn injury and other associated major trauma (defined as having an Injury Severity Score [ISS] above 15) will initially be referred to and managed by the relevant Major Trauma Service (the treatment of such patients should be agreed between the trauma service and the appropriate specialised burn service).

- Initial Assessment of burn injury in Emergency Departments is not a specialised service.
- Burn Care provision in local hospitals is not a specialised service (unless part of an agreed outreach/shared care arrangement with a specialised burn care provider).

NHS England Clinical Commissioning policies and Statements

3.5 Interdependencies with other services/providers

[please note the specific service co-dependencies for each tier of specialised burn care are listed in section 3].

Specialised burn services share service dependencies with trauma services, plastic surgery, including reconstructive surgery for cancers and other skin diseases, specialised paediatrics, including anaesthesia and Paediatric Intensive Care Unit (PICU), maxillofacial/craniofacial surgery and general critical care services.

Service Providers will ensure that there is effective communication and a common understanding of working practices between burn services and ambulance services, social services, emergency departments, the voluntary sector, and education, managed trauma and critical care clinical networks, and primary and secondary health care agencies.

Other Issues – applicable to all Specialised Burn Care Services

Patient and Carer Involvement

All specialised burn care services will have:

- Mechanisms for receiving feedback from service users and carers
- A rolling programme of audit of service users' and carers' experience
- Mechanisms for involving service users and, where appropriate, their carers in decisions about the organisation of the service

***Optimising Psychological Well-Being**

Burn injuries can cause a range of psychological and emotional issues to the patient and their families including anxiety, depression, altered body image, social prejudice and discrimination. Patients and their families need to be supported with information, advice and practical and emotional support to make a good recovery from burns, learning to live confidently with long term scarring and achieve their aspirations and

fulfilled lives. Ultimately burns patients should be valued and included as citizens, students and employees in society.

Psychological and social support will be provided by the whole burn care team including initial and on-going assessment and monitoring and delivery of appropriate NICE compliant interventions. In practice burns patients should be provided with advice and information to gain the life-skills to manage their burn. This includes a patient (and their family) having full information about their condition and its treatment, signposting them to support groups and other agencies if required, developing a positive outlook/belief system, learning to cope with their feelings, exchanging experiences with others with burn injuries and social skills training to manage other people's reactions to their altered appearance.

All the burn team should have an understanding of the psycho-social impact of burns and a changed appearance and its impact on the patient and their family. They should be able to identify the signs and symptoms of distress and anxiety of patients undergoing burn care and develop knowledge of the factors that predict patient coping, the benefits of psychosocial interventions and knowledge of referral pathways and support provision available.

Discharge criteria and planning

All specialised burn care services will have an agreed discharge procedure covering at least:

- arrangements for ensuring a copy of the latest plan of care is sent with the patient on discharge;
- General Practitioner (GP) communication/discharge letter within two days of discharge;
- feedback to referring service;
- patients have the contact details of whom they can telephone for advice after discharge.

Network guidelines covering the criteria and arrangements for discharge from a Burn Centre/Unit to a Unit/Facility nearer the patients' home should be agreed.

Service user / carer information

Patients and their families will have access to the following services (information about these services should be easily available):

- Accommodation for close family members (at Burn Centres/Units),
- Interpreter services (including access to British Sign Language),
- Patient Advice and Liaison Service (PALs)
- Social Workers
- Benefits Advice
- Spiritual Support
- Health Watch or equivalent organisation

- Written information will be offered to patients and their families covering at least:
    - members of the burn care team
    - how to contact the burn service
    - ward routines and layout
    - burns and the likely physical and psychological implication
    - support services and groups available
    - where to go for further information including useful websites
    - how to give feedback on the service including how to make a complaint
    - how to report safeguarding concerns
    - how to get involved in improving services
    - the opportunity to get involved in and access results of burns research and organ donation.
- Patients and their families whose first language is not English must be provided with appropriate professional interpreting and translation services.
- Written information will be offered to patients and their families on discharge from hospital covering at least:
    - pain and itch management
    - scar management
    - resuming activities
    - preventing burns in the future
    - toxic shock syndrome
    - sun exposure
    - psycho-social support available
    - follow-up appointment details and locations.

Emergency Preparedness

Planning for major unforeseen incidents or mass casualty incidents involving burn casualties presents major clinical and resource challenges. Burn injuries are common in major incidents which include fires as well as chemical, biological and radiological accidents. Specialised burn services in England and Wales must have a burn major incident plan to manage the response to major incidents involving a significant number of burn casualties [3].

NHS England Clinical Commissioning policies and Statements
None

4. Applicable Service Standards

4.1 Applicable national standards e.g. NICE

The Specialised Burn Care Service

The core requirements for the delivery of specialised burn services at each service level are described below:

Core Requirements for Burns Services:

A. The Burns Centres, Burns Units and Burns Facilities must be designated and are fully compliant with the Burns Care Standards.
B. Burns Centres, Burns Units and Burns Facilities provide full submission of data to the IBID database.
C. Centres need to be able to demonstrate ability respond effectively to major incidents involving a significant number of burns' casualties
D. Service must be part of a Burns ODN which is recognised by the AT responsible for commissioning specialised services

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

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5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)
To be inserted folloeing agreement of 14/15 CQUIN Schemes

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

The Provider's Premises are located at:
7. Individual Service User Placement
N/a

ANNEX 1 TO SERVICE SPECIFICATION:

PROVISION OF SERVICES TO CHILDREN

Aims and objectives of service

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

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

- 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 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 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) training[2] and should maintain the competencies so acquired[3] *. 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
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,accreditationaudit/qnic1.aspx)
- Staffing profiles and training - essential QNIC standards should apply.
- The child/ young person's family are allowed to visit at any time of day taking account of the child / young persons need to participate in therapeutic activities and education as well as any safeguarding concerns.
- Children and young people are offered appropriate education from the point of admission.
- Parents/carers are involved in the child/young persons care except where this is not in the best interests of the child / young person and in the case of young people who have the capacity to make their own decisions is subject to their consent.
- Parents/carers who wish to stay overnight are provided with accessible accommodation unless there are safeguarding concerns or this is not in the best interests of the child/ young person.

Applicable national standards e.g. NICE, Royal College

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

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

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

All staff who work with children and young people must be appropriately trained to provide care, treatment and support for children, including Children's Workforce

Development Council Induction standards (Outcome 14b Essential Standards of Quality and Safety, Care Quality Commission, London 2010).

Each hospital who admits inpatients must have appropriate medical cover at all times taking account of guidance from relevant expert or professional bodies (National Minimum Standards for Providers of Independent Healthcare,

Department of Health, London 2002)."Facing the Future" Standards, Royal College of Paediatrics and Child Health.

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

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

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

- Ensuring that staff and people who use services understand the aspects of the safeguarding processes that are relevant to them.
- Ensuring that staff understand the signs of abuse and raise this with the right person when those signs are noticed.
- Ensuring that people who use services are aware of how to raise concerns of abuse.
- Having effective means to monitor and review incidents, concerns and complaints that have the potential to become an abuse or safeguarding concern.
- Having effective means of receiving and acting upon feedback from people who use services and any other person.
- Taking action immediately to ensure that any abuse identified is stopped and suspected abuse is addressed by:

- having clear procedures followed in practice, monitored and reviewed that take account of relevant legislation and guidance for the management of alleged abuse
- separating the alleged abuser from the person who uses services and others who may be at risk or managing the risk by removing the opportunity for abuse to occur, where this is within the control of the provider
- reporting the alleged abuse to the appropriate authority
  reviewing the person's plan of care to ensure that they are properly supported following the alleged abuse incident

- Using information from safeguarding concerns to identify non-compliance, or any risk of non-compliance, with the regulations and to decide what will be done to return to compliance.
- Working collaboratively with other services, teams, individuals and agencies in relation to all safeguarding matters and has safeguarding policies that link with local authority policies.
- Participates in local safeguarding children boards where required and understand their responsibilities and the responsibilities of others in line with the Children Act 2004.
- Having clear procedures followed in practice, monitored and reviewed in place about the use of restraint and safeguarding.
- Taking into account relevant guidance set out in the Care Quality Commission's Schedule of Applicable Publications
- Ensuring that those working with children must wait for a full CRB disclosure before starting work.
- Training and supervising staff in safeguarding to ensure they can demonstrate the competences listed in Outcome 7E of the Essential Standards of Quality and Safety, Care Quality Commission, London 2010

All children and young people who use services must be

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

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

Key Service Outcomes

Evidence is increasing that implementation of the national Quality Criteria for Young People Friendly Services (Department of Health, London 2011) have the potential to greatly improve patient experience, leading to better health outcomes for young people and increasing socially responsible life-long use of the NHS. Implementation is also expected to contribute to improvements in health inequalities and public health outcomes e.g. reduced teenage pregnancy and 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

Appendix One

Quality standards specific to the service using the following template:

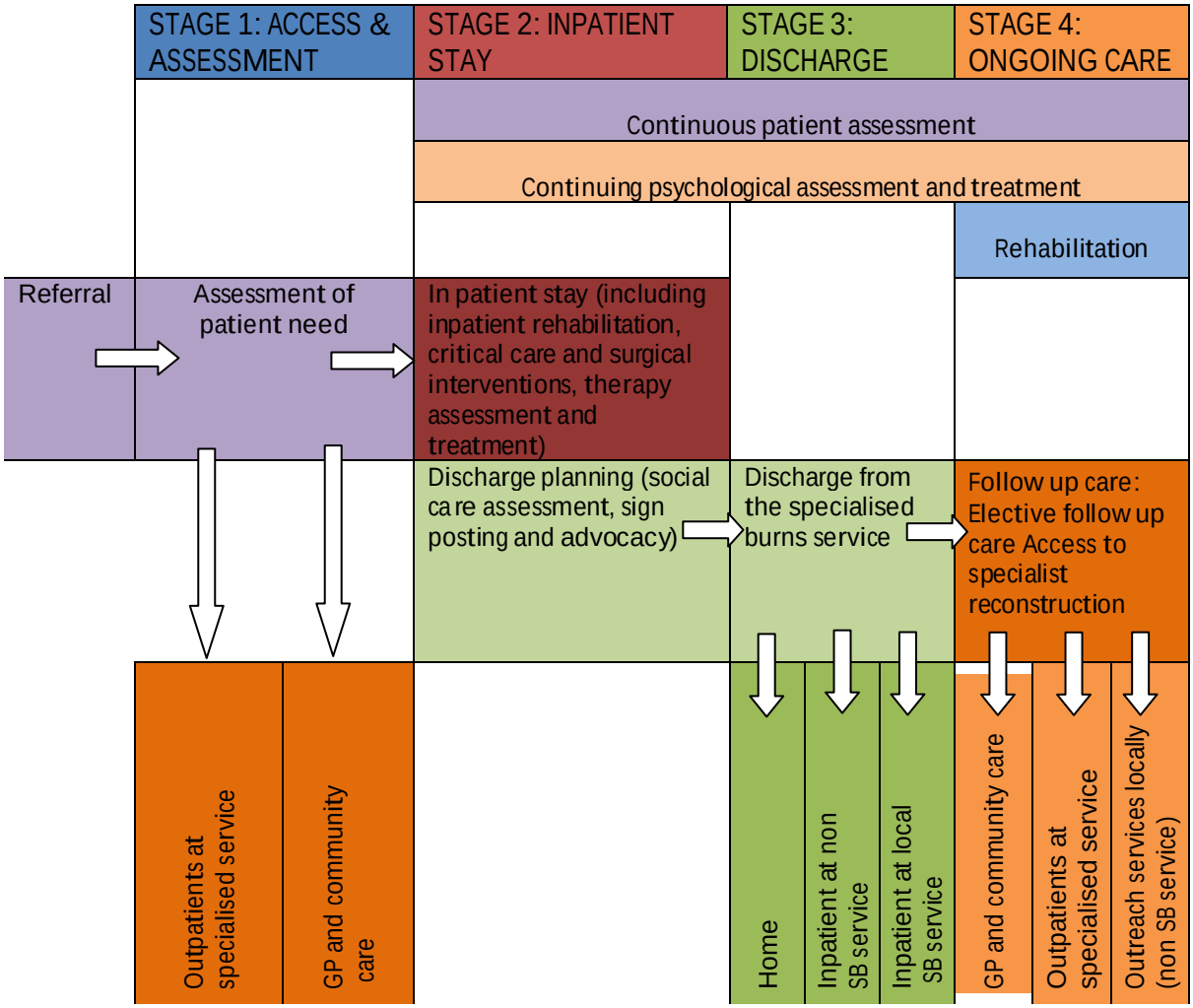
Quality Requirement	Threshold	Method of Measurement	Consequence of breach
Domain 1: Preventing people dying prematurely			
Unexpected Survivors	Number 100% Compliance	ABSI/Belgian Burn Scores/IBID Score	

Appropriate and timely referrals according to NBC referral guidance	with threshold guidance Time from first assessment to referral Time from referral to first burn service assessment or admission	IBID	General conditions 8 and 9
Accuracy of diagnosis of the severity of burn injury and state of the patient on arrival to specialist burn services	+/- X%	Variance in referring TBSA and inhalation and specialist burn service diagnosis	
Domain 2: Enhancing the quality of life of people with long-term conditions			
Optimal Scar Outcome (3a/b)	In patients identified with problem scarring	The Patient and Observer Assessment Scale at 6 weeks	General conditions 8 and 9
Functional Morbidity improved by intervention	% patients screened within 72 hours of admission	AusTom score +/- modified FIM	
Psychosocial wellbeing	% patients screened 6 months post-discharge	PedsQL Burn Specific Health care Brief	
Domain 3: Helping people to recover from episodes of ill-health or following injury			
Timely wound healing	% Burn wound cleaned and dressed within 6 hours	IBID	General conditions 8 and 9
	% complete excision of full thickness burns within 5 days of injury	For future inclusion in IBID	
Effective Clinical Management	% patients examined by a Consultant burns surgeon or nurse within 12 hours of	For future inclusion in IBID	

	admission		
Domain 4: Ensuring that people have a positive experience of care			
PROMS measures in development			General conditions 8 and 9
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm			
Optimal IV Fluid Resuscitation	% patients with evidence of over-resuscitation (Serum Na+ outside normal range)	IBID	General conditions 8 and 9
	% patients absence of pre-renal failure in resuscitation period +/- escharotomies	IBID	
Minimal Complication Rate - Preventing resistant infection	Number of episodes of sepsis as per ABA criteria	IBID	
	Incidence of resistant infections	IBID	
Unexpected readmission	% Unexpected readmission within 30 days	IBID	
Unexpected admission to ITU	Unplanned ITU readmission rate	IBID	
Staffing and Facilities in accordance with National Burn Care standards	Meets National Burn Care Standards 2013	Peer Review	
Prevention of pressure sores in major burns			

Appendix 2 The Specialised Burn Care Pathway

NHS England D06/S/a
Gateway Reference 01364



Appendix 3 National Burn Care Referral Guidance (Feb 2012)
http://www.specialisedservices.nhs.uk/library/35/national_Burn_care_Referral_Guidance.pdf

Change Notice for Published Specifications and Products

developed by Clinical Reference Groups (CRG)

Amendment **to the Published Products**

Product Name	Specialised Burns Care
Ref No	**D06/S/a**
CRG Lead	Amber Young

Description of changes required

Describe what was stated in original document	Describe new text in the document	Section/Paragraph to which changes apply	Describe why document change required	Changes made by	Date change made
	Put the previous year's specification in the new specification template, this has created a new section that needed populated linked to the National Outcome Framework and domains.	Section 2 and Appendix 2	To ensure consistency in specification formatting	CRG	October 2013
	To ensure consistency of format across our specification through using	Section 3.4 and 6.0 and Section 3.3	To ensure consistency in specification formatting	CRG	October 2013

	common sub headings, ensuring words of scope and IR are included in the exclusion and acceptance are. Clarity added on population covered.				