

## SCHEDULE 2 – THE SERVICES

### A. Service Specifications

<b>Service Specification No.</b>	A06/S/d
<b>Service</b>	Renal Dialysis – Intermittent Haemodialysis and Plasma Exchange To Treat Acute Kidney Injury
<b>Commissioner Lead</b>	
<b>Provider Lead</b>	
<b>Period</b>	12 Months
<b>Date of Review</b>	

#### 1. Population Needs

##### 1.1 National/local context and evidence base

##### Acute Kidney Injury (AKI) requiring dialysis

This service specification is confined to patients receiving acute intermittent haemodialysis (HD) for AKI or rarely for other indications such as poisoning, and patients receiving plasma exchange (PEX) when delivered by a renal service. It excludes AKI not requiring renal replacement therapy (RRT) as AKI not requiring RRT is not centrally commissioned. It also excludes AKI treated by Continuous Veno-Venous Haemofiltration (CVVH) which is usually delivered by critical care services for severely ill, unstable patients with multi-organ failure. Delivery of CVVH does not require on-site renal services. Therefore, for the purpose of commissioning, CVVH is not part of this specification as it is now standard treatment in nearly all level 3 critical care units, and will be commissioned from critical care services. Peritoneal dialysis for AKI is also not included in this specification as this is only very rarely used in England as treatment for AKI.

The severity of AKI varies from a relatively trivial component of another illness, to a serious life threatening condition. This area is hampered by lack of consensus over the definition of AKI. In the NICE guidance ( Acute Kidney Injury. Prevention, detection and

management of acute kidney injury up to the point of renal replacement therapy Clinical Guide line 169, issued August 2013) it was stated that “In developed countries AKI is seen in 13-18% of all people admitted to hospital”.(, Kerr M, Insight Health Economics. Economics of acute kidney injury. Royal College of Physicians of Edinburgh Consensus Conference on AKI. 2012; November 2012. Pannu N, James M, Hemmelgarn BR, Dong J, Tonelli M, Klarenbach S et al. Modification of outcomes after acute kidney injury by the presence of CKD. American Journal of Kidney Diseases. 2011; 58(2):206-213. Uchino S, Bellomo R, Goldsmith D, Bates S, Ronco C. An assessment of the RIFLE criteria for acute renal failure in hospitalized patients. Critical Care Medicine. 2006; 34(7):1913-1917). Of those patients with AKI so severe that death would occur without RRT, approximately half are nursed in a level 3 unit and receive CVVH. The other half are most often nursed in a level 1 or level 2 bed and virtually always receive intermittent haemodialysis (HD). There is considerable overlap between critical care teams and renal teams in the management of AKI in level 2 or 3 beds, and patients may move between treatment modalities depending on the clinical situation. However, in situations where a prolonged period of RRT is required for AKI, patients will inevitably move from CVVH to intermittent HD delivered by a renal service

The precise incidence of AKI requiring intermittent HD is not known in England as most published data comes from single centres. As a consequence of this lack of data, the cost to the health service is not exactly known, but it has been estimated that treating all AKI costs the NHS between £434 and £620 (millions) per annum (*Health Service Journal Supplement, 23/06/2011*). The cost for dialysis will be a significant fraction of this estimated cost. It is envisaged that the Renal Registry is to collect data on the incidence of AKI in future.

AKI has a high morbidity and mortality. Where AKI occurs in conjunction with the failure of 2 or more organs in-hospital mortality is 50-70% in most published series. Single organ failure requiring RRT has an in-hospital mortality of about 10-20% in most series (*Uchino et al JAMA: 2005, 294(7)813: Bagshaw et al Crit Care 2005: 9(6) R700: Liano et al Kidney International: 1996, 50(3) 811*). A significant number of patients who develop AKI will either not recover function and require RRT for the rest of their lives, or develop CKD which may lead to ERF at some point in the future (*Lo et al, Kidney International 2009: 76, 893-899*).

Despite the severity and frequency of AKI, treatment is often less than good. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) AKI enquiry, which was confined to patients who had died with AKI, highlighted that 20% of cases of AKI developing in hospital were predictable and avoidable, and that 50% of patients received care that was considered to be less than good ([www.ncepod.org.uk/2009aki.htm](http://www.ncepod.org.uk/2009aki.htm)). On a similar theme, The Acute Kidney Injury Capacity Survey -England and Wales (March 2011) was carried out on World Kidney Day 2011. This survey looked at the availability of renal and critical care beds. It highlights the challenges faced in managing AKI, including high levels of bed occupancy and significant numbers of patients awaiting transfer for specialist management. These 2 surveys highlight the need for a robust national policy with key quality indicators and outcomes for the treatment of AKI.

### **Therapeutic Plasma Exchange**

Plasma exchange is a treatment which is occasionally performed by renal services in

treating some forms of AKI (such as microscopic polyangiitis or anti-glomerular basement disease) in an attempt to recover renal function or treat complications of the underlying disease (for example pulmonary haemorrhage).

Plasma exchange can also be used for conditions that do not cause AKI, but treatment is delivered by a renal service using a central venous dialysis catheter. These conditions are usually neurological or haematological. Patients with these conditions are usually managed jointly with other clinical teams, but the plasma exchange treatment and expertise may be delivered by the renal service depending on local arrangements which is why it is included in this specification.

There is no national dataset registering the number of plasma exchanges performed by renal units in England, but anecdotal evidence from individual renal units estimate the number to be in the region of 100-200 treatments per million population per year for combined AKI and non-AKI indications. This specification excludes plasma apheresis which is delivered by haematology services, usually without the need for a central venous catheterisation.

## 2. Outcomes

### 2.1 NHS Outcomes Framework Domains & Indicators

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

The overall aim of the service is to provide a clinically safe and effective service that will improve the outcomes for patients with AKI by providing timely access to therapies and to reduce the acute mortality and late morbidity of these patients.

It is expected that all renal units will have the capacity to record all episodes of AKI requiring HD or PEx. Renal units are to submit data to the Renal Registry and the data requirements particular to AKI and to capture data as per the outcomes below.

Patient reported outcome and experience measures should be prioritised, and should be

the principle barometer of success. Improved quality of life and experience for both patients and carers should be sought.

Expected outcomes (Domain 1,2, 3 and 5)

<b>Outcome</b>	<b>Measurable output</b>
To reduce any delays in transfer to a renal unit from another hospital for treatment of AKI requiring hd or PEx.	The time between agreement to request for transfer to and actual arrival at renal centre.
To reduce the incidence of MRSA and MSSA bacteraemia related to vascular access	Number of bacteraemia per 100 patients with a dialysis catheter requiring HD or PEx for AKI
For patients to receive treatment in the most appropriate setting	Number of patients with AKI requiring escalation of care to level 2 or 3 within 24 hours of admission to a renal ward.
To improve patient outcome including incidence of acute mortality and late morbidity	Length of stay Hospital mortality 90 day mortality Incidence of surviving patients remaining independent of dialysis at 90 days

### 3. Scope

#### 3.1 Aims and objectives of service

This specification sets out what is required of a clinically safe and effective organisation that is providing care for adults (18 years of age and older) requiring intermittent HD for AKI, or plasma exchange delivered by a renal service. It describes the interventions and actions required along the patient pathway, as well as entry and exit points. It is based upon evidence-based care and treatment models.

AKI requiring dialysis, and many of the diseases that require treatment with plasma exchange, have a high mortality rate and significant late morbidity. The aim of the service is to provide timely access to therapies, and to minimise both the acute mortality and late morbidity.

To provide an adequate dialysis service for AKI and plasma exchange service, the unit must provide the following:

- The service will encompass local referral guidelines
- Communication links between referring clinicians and renal units at both point of entry and exit
- Provision of intermittent haemodialysis for AKI
- Provision of plasma exchange via a central venous dialysis catheter for AKI or other non-AKI conditions that respond to plasma exchange

- Access to renal specialists and non-clinical expertise
- Provision of vascular access for haemodialysis or plasma exchange
- Access to diagnostic services (radiology, pathology and microbiology)
- Access to other medical specialties that may be involved in the management of patients with AKI or requiring plasma exchange (urology, haematology, interventional radiology, vascular and general surgery, cardiology, critical care services, clinical microbiology, diabetes services, cancer services, end of life services and obstetrics)
- Access to non-medical specialties involved in the management of patients with AKI or patients requiring plasma exchange (pharmacy services, physiotherapy and occupational therapy, dietetic services psychiatric and/or psychological services and social work services)
- Provision of adequate discharge planning including rehabilitation and follow up with an appropriate health care professional team

### 3.2 Service description/care pathway

Intermittent haemodialysis for patients with severe AKI is a well established treatment modality. It is always delivered as part of the portfolio of services delivered by a main renal unit. This integration into a comprehensive renal service allows for economies of scale and sharing of expertise, as often the delivery of intermittent haemodialysis for AKI uses the same equipment and staff used to deliver services for established renal failure.

Plasma exchange (PEX) to treat AKI is most often delivered as part of the portfolio of services delivered by a main renal unit. However this is not the situation in all renal units, as PEX is a much less common form of treatment than intermittent haemodialysis. In this situation, either referral to a unit which can deliver plasma exchange or on site delivery of plasma exchange by a different clinical team is required. Where a renal unit does not provide plasma exchange, robust arrangements have to be in place to provide plasma exchange within 24 hours of the need being identified.

#### Entry To The Pathway

Primarily, patients will be identified with AKI either in a hospital with a comprehensive renal service or a hospital without an on site renal service. Frequently the identification will be made in primary care. The provision for transfer to a hospital with on-site renal services and emergency RRT should be available 24 hour, 7 days a week. It will include that referrers have the opportunity to discuss cases promptly with a suitably trained renal specialist (that is, a doctor with a certificate of completion of specialist training (CCST) in renal medicine, a non-consultant grade doctor with more than 4 years post registration experience, or a doctor in an approved Specialist Training post in renal medicine).

- **From other hospital departments**  
Locally derived guidelines (for example, via abnormality flags on pathology results) should encourage timely referral into the in-hospital renal service.
- **From hospitals that do not have an on-site renal unit**  
Renal units will have clear communication guidance to local hospitals to

ensure prompt access to renal specialists to discuss cases; this will include written criteria to ensure safe transfer.

- **From primary care** Renal units will have clear communication guidance with local primary care to ensure prompt access to renal specialists to discuss cases.

## People

It is preferable that renal services will have a designated clinical lead to co-ordinate local policies; the multi-disciplinary team required managing patients with AKI; and AKI audit.

Renal units will be staffed so that there is access to medical clinical expertise from trained renal specialists on a daily basis, and doctors in training to provide resident cover.

Renal units will be staffed so that there is access to trained nurses able to deliver intermittent haemodialysis 24 hours a day 7 days a week, separate from the delivery of treatment to patients with established renal failure. Nurse to patient ratios for delivery of HD for AKI or PEx should be 1:1.

All staff prescribing (doctors) or delivering (nurses) intermittent haemodialysis or plasma exchange must be competent to prescribe or deliver such treatment, and will have satisfactorily completed a competency based training program.

Renal units will be staffed so that there is access to trained nurses to deliver plasma exchange seven days a week within 24 hours of a patient being identified as requiring PEx. For the condition of thrombotic thrombocytopenia purpura, PEx should ideally be delivered within 12 hours of presentation.

Renal units will be staffed so that there is access to dietetic, and pharmacy expertise five days a week within office hours.

Renal units will have access, within days, to physiotherapy, social work, and psychological and/or psychiatric support (for example, for patients developing AKI following a drug overdose).

Renal units providing plasma exchange should have access to nursing staff that can administer (non-cancer) chemotherapy as adjuvant treatment, where intravenous chemotherapy is indicated, 5 days a week during office hours, and will have the ability to schedule such adjuvant therapy in an appropriate and timely fashion.

Doctors in training will have sufficient exposure and training in the management of AKI to develop appropriate competencies. (As measured by satisfactory appraisal and review of their portfolio by their clinical supervisor)

## Supporting Technology

All renal units will have sufficient IT facility to capture and record all episodes of AKI requiring HD or PEx. This is essential to capture all episodes for the purpose

of commissioning, and also for the purpose of audit to measure outcomes such as mortality rates.

### **Initiation of Treatment**

The precise timing of the need to institute either intermittent haemodialysis or plasma exchange will be made by a renal specialist, as defined above, in a manner that minimises risks to patients.

### **Vascular Access**

Dialysis access needs to be available in appropriate settings 24 hours a day. Appropriate settings include operating theatres, radiology departments and clean areas on renal wards.

Renal units will have access to central venous catheters designed for dialysis access.

All renal services will have the ability to place un-tunneled central venous dialysis catheters 24 hours a day 7 days a week.

All renal services will have the ability to place tunneled venous dialysis catheters 5 days a week within normal working hours as a minimum.

Renal units will have in place strategies to minimise the risk and also deal with the complications of dialysis access, such as health care associated infections and traumatic damage to blood vessels.

### **Technology**

Haemodialysis machines as a minimum, will be capable of delivering bicarbonate buffered dialysis and ultrafiltration, and reach the standards for safety and water purity as set out by the Renal Association guidelines. All machines will reach European Conformity requirements (CE mark).  
(<http://www.renal.org/Clinical/GuidelinesSection/Guidelines.aspx>)

Plasma exchange will be performed with any validated plasma exchange machine favoured by an individual unit and will be appropriately CE marked.

### **Exit from the pathway**

The majority of patients who survive will recover renal function so that dialysis is no longer necessary. The renal unit will have handover documentation to allow the patient's prompt return to the referring service. The patient maybe re-referred back to another medical team in the same hospital; a medical team in a different referring hospital: rehabilitation services in the community: or the general practitioner if discharged home.

All patients will receive written documentation on discharge outlining the diagnosis, the care they received, an updated list of medication, and a plan for future management and monitoring. This will include appropriate rehabilitation if required.

For those patients who do not recover renal function they will transfer care to the unit's program for established renal failure and a suitable care plan for ERF will be initiated. Whether a patient is likely to recover function or not may not be immediately apparent: for those patients who are deemed to have irreversible AKI, counselling and preparation for long term RRT should be planned before discharge from hospital . These options for long term RRT include conservative care, peritoneal dialysis, long-term haemodialysis and transplantation.

### **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 GP Practice in Wales, but INCLUDES patients resident in Wales who are registered with a GP Practice in England.

This service specification is confined to any adult patient, regardless of nationality, requiring life-saving intermittent dialysis for AKI, or organ / life -saving treatment requiring plasma exchange delivered by a renal service. This specification refers to adults over the age of 18 years. Some young people aged less than 18 years may be best treated in an adult service, by mutual consent. All patients with end-stage kidney disease should be considered for home haemodialysis.

When treating children, the service will additionally follow the standards and criteria outlined in the Specification for Children's services (attached as Appendix 2 to this specification)

### **3.4 Any acceptance and exclusion criteria and thresholds**

This service specification excludes the treatment of children with AKI requiring dialysis: an adult is defined as any patient 18 years of age and over. It includes treatment of any adult, referred from any appropriately trained health care professional, where dialysis or plasma exchange is required as a life or organ saving treatment.

The geographical areas covered by the service include the catchment populations of all Clinical Commissioning Groups (CCGs) in England. Any patient presenting with AKI to renal services in England will receive lifesaving or organ saving treatment as soon as is clinically indicated from that renal service irrespective of the region or country that the patient originates from. Occasionally, patients will wish to receive treatment from a renal service outside the catchment area from which they presented: in such cases repatriation should take place at the earliest opportunity that does not jeopardise patient safety.

### **3.5 Interdependencies with other services/providers**

#### **Co-located services**

#### **Radiology**

There will be access to renal ultrasound within 24 hours of presentation as a minimum.

When pyonephrosis is suspected renal ultrasound to be performed within 6 hours of assessment

There will be access to expertise to place nephrostomies within 12 hours of diagnosis

There will be access to fluoroscopy to place venous access catheters five days a week 09.00 to 17.00 as a minimum

### **Laboratory services**

There will be access to routine biochemistry, haematology and blood transfusion services 24 hours a day.

Renal units will have urgent access to blood products, including plasma and plasma products, 24 hours a day 7 days a week.

There will be access to process specialised tests, such as immunology and specialty biochemistry, five days a week.

There will be access to allow processing of renal biopsies five days a week.

### **Interdependent Services**

There will be access to the following medical specialties 24 hours a day: urology, critical care, general and vascular surgery, cardiology, haematology and obstetrics.

There will be available access to level 2 and 3 beds 24 hours a day

There will be access to interventional radiology and clinical microbiology 7 days a week

There will be access to diabetes services and blood and solid organ cancer services 5 days a week.

### **Related Services**

There will be access to dieticians, physiotherapy, occupational therapy, social work, psychiatric and/or psychological services and pharmacy support five days a week, 09.00 to 17.00.

## **4. Applicable Service Standards**

### **4.1 Applicable national standards e.g. NICE**

Renal National Service Frameworks Parts 1 and 2

Renal Association Clinical Practice Guidelines  
<http://www.renal.org/Clinical/GuidelinesSection/Guidelines.aspx>

KDIGO AKI guidelines 2012

[http://www.kdigo.org/clinical\\_practice\\_guidelines/pdf/KDIGO-AKI-Suppl-Appendices-A-F\\_March2012.pdf](http://www.kdigo.org/clinical_practice_guidelines/pdf/KDIGO-AKI-Suppl-Appendices-A-F_March2012.pdf)

Acute Kidney Injury Protocols and Guidelines Adapted with permission from the North Central London AKI Network Version 1.0 September 2011 <http://www.londonaki.net/>

Acute Kidney Injury: Prevention, detection and management of acute kidney injury up to the point of renal replacement therapy  
Clinical Guideline 169 August 2013. [Guidance.nice.org.uk/cg169](http://guidance.nice.org.uk/cg169)

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

**5. Applicable quality requirements and CQUIN goals**

**5.1 Applicable quality requirements (See Schedule 4 Parts A-D)**

**5.2 Applicable CQUIN goals (See Schedule 4 Part E)**

**6. Location of Provider Premises**

**The Provider's Premises are located at:**

## Appendix 1

Quality standards specific to the service using the following template:

Quality Requirement	Threshold	Method of Measurement	Consequence of breach
<b>Domain 1: Preventing people dying prematurely</b>			
To reduce the incidence of MRSA and MSSA bacteraemia related to vascular access	No more than one bacteraemia per 25 patients treated with intermittent haemodialysis or plasma exchange for AKI. Service to comply with national standards.	Number of bacteraemia per 100 patients with a dialysis catheter requiring intermittent haemodialysis for AKI or plasma exchange. Annual audit.	As per Standard NHS Contract General Conditions Clause 9 (GC9) Remedial Action Plan
<b>Domain 2: Enhancing the quality of life of people with long-term conditions</b>			
To improve patient outcome including incidence of acute mortality and late morbidity	Benchmark and improvements in reported length of stay, hospital mortality, 90 day mortality and incidence of surviving patients.	Annual audit	As per Standard NHS Contract General Conditions Clause 9 (GC9) Remedial Action Plan
<b>Domain 3: Helping people to recover from episodes of ill-health or following injury</b>			

To reduce any delays in transfer to a renal unit from another hospital for treatment of AKI requiring hd or PEx.	Transfer occurring more than 24 hours after referral	Interval between referral and arrival of patients requiring transfer to a renal centre.  Annual Audit.	As per Standard NHS Contract General Conditions Clause 9 (GC9) Remedial Action Plan
------------------------------------------------------------------------------------------------------------------	------------------------------------------------------	--------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------

**Domain 4: Ensuring that people have a positive experience of care**

Feedback from in-patient experience	>75% "recommend care" as defined in test	Global scores in friends and family test for renal wards where patients with AKI are nursed.	As per Standard NHS Contract General Conditions Clause 9 (GC9) Remedial Action Plan
-------------------------------------	------------------------------------------	----------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------

**Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm**

For patients to receive treatment in the most appropriate setting		Number of patients with AKI requiring escalation of care to level 2 or 3 within 24 hours of admission. Annual audit.	For patients to receive treatment in the most appropriate setting
-------------------------------------------------------------------	--	----------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------

## APPENDIX 2:

### 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 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 (DOH) & 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 – DOH

#### Imaging

- All services will be supported by a 3 tier imaging network ('Delivering quality imaging services for children' DOH 13732 March 2010). Within the network

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

- **Specialist Paediatric Anaesthesia**

- Wherever and whenever children undergo anaesthesia and surgery, their particular needs must be recognised and they should be managed in separate facilities, and looked after by staff with appropriate experience and training.<sup>1</sup> All UK anaesthetists undergo training which provides them with the competencies to care for older babies and children with relatively straightforward surgical conditions and without major co-morbidity. However those working in specialist centres must have undergone additional (specialist) training<sup>2</sup> and should maintain the competencies so acquired<sup>3</sup> \*.
- These competencies include the care of very young/premature babies, the care of babies and children undergoing complex surgery and/or those with major/complex co-morbidity (including those already requiring intensive care support).
- As well as providing an essential co-dependent service for surgery, specialist anaesthesia and sedation services may be required to facilitate radiological procedures and interventions (for example MRI scans and percutaneous nephrostomy) and medical interventions (for example joint injection and intrathecal chemotherapy), and for assistance with vascular access in babies and children with complex needs such as intravenous feeding.
- Specialist acute pain services for babies and children are organised within existing departments of paediatric anaesthesia and include the provision of agreed (hospital wide) guidance for acute pain, the safe administration of complex analgesia regimes including epidural analgesia, and the daily input of specialist anaesthetists and acute pain nurses with expertise in paediatrics.
- \*The Safe and Sustainable reviews of paediatric cardiac and neuro- sciences in England have noted the need for additional training and maintenance of competencies by specialist anaesthetists in both fields of practice.
- **References**

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

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

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

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

- Facilities and environment – essential Quality Network for In-patient CAMHS (QNIC) standards should apply (<http://www.rcpsych.ac.uk/quality/quality,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*, 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)  
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 dieticians, physiotherapists, occupational therapists, speech and language therapy, psychology, social work and CAMHS services within nationally defined access standards.
- All children and young people should have access to a professional who can undertake an assessment using the Common Assessment Framework and access support from social care, housing, education and other agencies as appropriate
- All registered providers must ensure safe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines (Outcome 9 *Essential Standards of Quality and Safety*, Care Quality Commission, London 2010). For children, these should include specific arrangements that:
    - Ensures the medicines given are appropriate and person-centred by taking account of their age, weight and any learning disability
    - ensuring that staff handling medicines have the competency and skills needed for children and young people's medicines management
    - Ensures that wherever possible, age specific information is available for people about the medicines they are taking, including the risks, including information about the use of unlicensed medicine in paediatrics.
- Many children with long term illnesses have a learning or physical disability. Providers should ensure that:
    - They are supported to have a health action plan
    - Facilities meet the appropriate requirements of the Disability Discrimination Act 1995
    - They meet the standards set out in *Transition: getting it right for young people. Improving the transition of young people with long-term conditions from children's to adult health services*. Department of Health Publications, 2006, London.