

**2013/14 NHS STANDARD CONTRACT
FOR PAEDIATRIC SURGERY: CHRONIC PAIN**

**PARTICULARS, SCHEDULE 2 – THE SERVICES, A - SERVICE
SPECIFICATIONS**

Service Specification No.	E02/S/b
Service	Paediatric Surgery: Chronic Pain
Commissioner Lead	
Provider Lead	
Period	12 months
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Definition

Children and young people (CAYP) who suffer chronic pain and pain associated disability (disease and non-disease related) that is refractory to primary, secondary and non-specialised tertiary healthcare input)

This specification covers all children under the age of 18 including infants older than three months.

Background

Chronic pain in CAYP is recurrent or persistent pain which persists beyond the usual course of an acute disease or which is associated with an underlying chronic condition.

Traditionally, chronic pain in CAYP has been considered to be present after a period of three months. However, there are definite chronic pain conditions, such as complex regional pain syndrome and some cancer pains, which manifest before this period has elapsed.

CAYP with significant chronic pain are normally referred to secondary or tertiary paediatric services, where most are diagnosed and managed well. A small cohort of these patients will prove to have a refractory, disabling condition, which prevents

normal integration into developmentally appropriate activities (school, family life, independent social activity, physical activities etc.) and need onward referral to a highly specialist chronic pain service. These children and their families require multidisciplinary input to manage their pain and support their rehabilitation.

Chronic pain services will not be present in every children's specialist centre and therefore highly specialist chronic pain services will need to work within a network of care with arrangements for advice and referral.

"Multidisciplinary management of patients with chronic pain alleviates pain and suffering, aids functional restoration and reduces the socioeconomic burden of pain for the individual, health care systems and the community"

<http://www.rcoa.ac.uk/system/files/CSQ-GPAS7-ChronicPain.pdf>

Incidence and Prevalence

The prevalence of chronic pain in children, as currently defined, is reported between 6-25 %; (Perquin, Roth-Iskiett). As stated previously, the majority of these CAYP are managed and rehabilitated effectively in primary, secondary and non-specialised tertiary centres.

A minority of children and families with chronic pain develop pain associated disability; they become deeply distressed and disabled with complex problems including school attendance, peer relationships and physical/social functioning. Parental well-being and employment are severely affected.

There is a significant impact on health resource (Sleed et al). For these CAYP with severe disability clinical experience and reports from several countries have supported the need for multidisciplinary services. This approach is advocated by the Faculty of Pain Medicine, the British Pain Society and the American Pain Society.

Based on current service activity figures it is estimated that there are approximately 2,000 patients per annum nationally who would require referral to highly specialised paediatric chronic pain services.

National Policy Initiatives

The Faculty of Pain Medicine of the Royal College of Anaesthetists is the statutory body that sets standards for pain services nationally. The British Pain Society also sets out standards for pain service and unless advised otherwise by commissioners, providers are expected to work to the standards set by these bodies and any successor organisations standards and objectives. As these will change over time, guidance is referenced here, but it is not the expectation of commissioners that this is static and complete but rather it is statement of current policy which evolves. Current guidance advocates that prevention and management of persistent pain in adults,

children and young people should be a fundamental objective of any health service. Good practice should ensure provision of a high quality, adequately resourced, multi-professional service dedicated to the care and support of patients with persistent pain and to the on-going education and development of staff.

- Royal College of Anaesthetists (2011) Guidance on the provision of services for chronic pain management
- Chronic Pain Policy Coalition (2012) A report of the Pain Summit 2011
- British Pain Society (2010) Cancer Pain Management
- British Pain Society (2005) The use of drugs beyond licence in palliative care and pain management
- Faculty of Pain Medicine (2010) Best practice in the management of epidural analgesia in the hospital setting
- Royal College of Anaesthetists (2012) Raising the Standard – A compendium of Audit Recipes for continuous quality improvement in anaesthesia

2. Scope

2.1 Aims and objectives of service

The aim of the highly specialist chronic pain service is to provide a timely, specialist multi-disciplinary approach to the diagnosis and management of chronic pain in CAYP and their families, putting in place a patient specific management plan which alleviates pain, aids functional restoration and reduces the socioeconomic burden of pain for the family. The mental health needs of the child will be considered and addressed throughout the pathway utilising all MDT members.

Objectives

- Provide a multi professional patient specific assessment of the patient's needs and put in place an individual management plan
- Promote the highest possible quality of life for CAYP with pain and pain associated disability and their families
- Provide accurate diagnosis
- Provide pharmacological, physical, psychological and behavioural interventions that support patients, the whole family unit, including siblings, in managing their pain, enabling them to lead more normal lives with reduced disability
- Provide interventional pain procedures when appropriate
- Promote independence and wellbeing for patients through the provision of structured self-management support, with concomitant benefits of fewer inappropriate medical appointments and readmissions
- Ensure that effective communication takes place between all related professionals and service providers
- Provide in-patient support particularly around the management of pain problems of high medical and psychological complexity

- To ensure that transition to adult chronic pain management services is managed effectively to minimise disruption to management and unnecessary suffering to the patient

2.2 Service description/care pathway

The service comprises of the following elements:

- Assessment of referral
- Out-patient assessment with patient and family, or in-patient consultation where the patient is already an in-patient, to confirm or make a diagnosis of chronic pain
- Multidisciplinary team (MDT) discussion with relevant professionals – to agree patient specific management plan
- Follow up appointments with therapists to provide pain management strategies
- Follow up out-patient appointments to monitor patient
- In patient attendance (where deemed appropriate)
- Intensive residential pain management programme (where deemed appropriate)
- Resource to support teaching and training, audit and research

Referral

The majority of referrals will come from secondary and tertiary paediatric specialists and will be under their care for:

- Disease management e.g. Inflammatory bowel disease, Juvenile idiopathic arthritis, Migraine with a pain management plan
- Painful conditions e.g. Irritable bowel syndrome, severe musculoskeletal pain (e.g. complex back pain)

Onward referral to a highly specialist chronic pain service, which are generally located in a teaching hospital environment , working closely with community and local pain management services, will occur where it is considered that highly specialist resources and advice are indicated or where the patient has widespread chronic pain and significant disability. Other referrals from secondary and tertiary paediatric specialists will be for specific pain syndromes e.g. Complex regional pain syndrome, Post-operative neuropathic pain, tumour related neuropathies.

Some referrals will come from adult pain physician.

GPs may occasionally also refer directly to chronic pain services, but it would be expected that this would only normally happen where a paediatric secondary/tertiary opinion has been sought and provided.

A further small cohort of patients will present via the Emergency Department and may be admitted as in-patients under paediatric medical or surgical services.

Initial Care

- Patients must be referred within British Pain Society (BPS) pathways and guidelines
- Patients will normally be seen in a multi-disciplinary out-patient appointment by an appropriately skilled team
- The multidisciplinary team (MDT) members will include:
- Pain Specialists – defined by achievement of a fellowship from the Faculty of Pain Medicine or equivalent
- Specialist Paediatric Anaesthetists
- Consultant Paediatrician
- Clinical Psychologists and *paediatric psychiatry liaison support (where indicated)
- Nurses
- Occupational Therapists
- Physiotherapists
- Access to an associated team, e.g. Applied Psychologists such as Clinical, Counselling or Health Psychologists and Psychotherapists
- Social workers will also be required
- This team will require appropriate accommodation and administrative support. Regular multidisciplinary team meetings will occur.
- Additional specialty input will be required as determined by the pain specialist, for example this will include all specialists likely to refer to the service (see section 2.5) and in addition, radiology, pharmacy, child psychiatry

On-going care

The majority of patients, following intervention from highly specialised units have a significant improvement in their social and physical functioning (returning to full-time school and less dependent on healthcare resources). Pain becomes less bothersome and, in some cases, ceases completely. These patients can be discharged from the pain service. For those with underlying disease (cancer, arthritis etc) there is an open channel of communication between the patient, family and local team with the specialised pain centre. A minority of patients have pain and associated symptoms that continue in older adolescence; these patients are entered into a transition period with adult pain services. Transfer to adult services should not generally occur before age 18 (unless as a result of patient choice).

A small number of patients will require admission as day cases or inpatients for interventional nerve blocks or because the child and family are unable to cope with distressing pain symptoms at home.

A small number of patients and their families, following assessment with the expert pain team, will be put forward for an intensive, targeted residential pain management programme.

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)

- **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)

Specifically, this service covers all children under the age of 18 including infants older than three months who require onward referral to a highly specialist chronic pain service where it is considered that specialist resources and advice are indicated or where the patient has widespread chronic pain.

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

2.4 Any acceptance and exclusion criteria

Patients up to age 18, who have previously been seen by a paediatric secondary or tertiary specialist for management of their chronic pain would be eligible for referral to the service and have defined chronic pain. It is difficult to be rigid about referral criteria, but generally it would normally include: significant absence from school because of pain; frequent, repeated attendance at the Emergency Department; high frequency of urgent paediatric or pain outpatient appointments; prolonged in-patient episodes due to uncontrolled pain and pain associated symptoms. Acceptance criteria would remain at the discretion of paediatric specialists who feel that the child's symptoms are disabling and not well managed by their expertise.

Examples of appropriate referrals would be: children with specific disease related pain that has become unmanageable – e.g. childhood arthritis leading to intractable limb pain, inflammatory bowel disease leading to chronic abdominal pain and children with specific pain conditions such as complex regional pain syndrome, neuropathic pains, juvenile fibromyalgia, intractable headaches and cancer patients whose pain is not controlled by the policies and procedures of the oncology unit

(this is particularly relevant for children with tumours involving major nerves).

Referrals will need to include:

- That the referral is considered appropriate by the specialist centre
- That the referring specialist is not able to manage the child's pain symptoms
- All investigations completed, results obtained and feedback to the patient/family
- All appropriate simple analgesics have been considered and utilised using WHO analgesic ladder.
- An explanation to the patient and family of the multi-disciplinary pain management service has been given and the patient/family is in agreement with the referral
- Where the referral has not originated from a Consultant, the referral must have been agreed by the responsible Consultant

2.5 Interdependencies with other services

- Services will need to link with: Specialists in Paediatric: Rheumatology, Gastroenterology, Anaesthesia, Neurology, Orthopaedic Surgery, General Surgery, Urology, Dentistry, Neurosurgery, Plastic Surgery, ENT Surgery, Oncology, Psychology, Mental Health Services, Community Teams and Palliative Care.
- Links to social services, primary care (GP's and community nursing) and educational services are essential. Links to adult chronic pain services are essential to ensure robust transitional arrangements are in place
- Very occasionally, a child or young person will require interventional management that is provided only in adult highly specialised pain management centres.
- It is expected that services will adhere to relevant guidance in:
 - a) Specialised Paediatric Generic Specification – (see Annex 1)
 - b) Adult highly specialised pain management services - (See Service Specification D8)

The strategic vision is for chronic pain services to work within a clinical network and the footprints and strategic plan for this will be developed.

3. Applicable Service Standards

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

As per the intercollegiate 2010 document all clinical staff involved with patients must be trained to an appropriate level, as per the levels specified in the document:

- Level 1: Non Clinical Staff working in health care settings
- Level 2: Minimum level required for clinical staff who have some degree of contact with children and young people and/or parents/carers
- Level 3: Clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns

CRB Checks - providers will ensure that all staff involved with patients will have undergone an enhanced CRB check.

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).

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).

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

Applicable national standards:

- National Standards for Chronic Pain services do not currently exist (July 12) however, providers will follow the guidance from the Royal College of Anaesthetists – Guidance on the Provision of Services for Chronic Pain Management” (July 2011)
- commissioning tertiary and specialised services for children and young people. RCPCH 2004
http://www.longtermventilation.nhs.uk/Rainbow/Documents/RCPCH_Tertiary%20commissioning.pdf
- DH (2004) National service framework for children, young people and maternity services.
- Royal College of Anaesthetists (2012) ‘Raising the standard: a compendium of audit recipes: chronic pain services’
- International Association for the Study of Pain (2009) ‘Desirable characteristics for pain treatment facilities’
- Royal College of Anaesthetists (2005) A National Strategy for Academic Anaesthesia
- Report of the Children and Young People’s Health Outcomes Forum
 - Safeguarding children and young people-roles and competencies for health care staff. Intercollegiate document, September 2010.
www.rcpch.ac.uk/safeguarding
- Protecting children and young people: responsibilities of all doctors. GMC Sept 2012. www.gmc-uk.org/guidance

4. Key Service Outcomes

Clinical Outcome (baseline and six and 12months post treatment)

- PedQL questionnaire – paediatric quality of life
- Bath Adolescent Pain Questionnaire – (BAPQ) change in physical measures and pain related anxiety (ages 11-18)
- Back to School – Baseline % term attendance and 1 year post treatment % term attendance
- Patient Experience: NHS Outpatients Questionnaire
- Parental SF-12 health survey
- Patient efficiency
 - % of patients assessed within 3 months from referral and % of patients assessed/entering multidisciplinary treatment pathway within 6 weeks following assessment (18 week target)
 - & of patients discharged to a paediatrician within 12 months from referral

ANNEX 1 TO SERVICE SPECIFICATION:

PROVISION OF SERVICES TO CHILDREN

Aims and objectives of service

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

The generic aspects of care:

The Care of Children in Hospital (Health Service Circular 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 (DH)

Imaging

All services will be supported by a 3 tier imaging network ('Delivering quality imaging services for children' DH 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
- All equipment will be optimised for paediatric use and use specific paediatric software.

Specialist Paediatric Anaesthesia

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

As well as providing 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. RCoA 2010 www.rcoa.ac.uk
2. Certificates of Completion of Training (CCT) in Anaesthesia 2010
3. Continuing Professional Development (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 41 *Essential Standards of Quality and Safety*, Care Quality Commission, London 2010)

Key Service Outcomes

Evidence is increasing that implementation of the national Quality Criteria for Young People Friendly Services (Department of Health, London 2011) have the potential to greatly improve patient experience, leading to better health outcomes for young people and increasing socially responsible life-long use of the NHS.

Implementation is also expected to contribute to improvements in health inequalities and public health outcomes e.g. reduced teenage pregnancy and STIs, and increased smoking cessation. All providers delivering services to young people should be implementing the good practice guidance which delivers compliance with the quality criteria.

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

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

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

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

supervised by a qualified Hospital Play Specialist.

- **A16.14** Children are required to receive education when in hospital for more than five days; the Local Education Authority has an obligation to meet this need and are contacted if necessary.
- **A18.10** There are written procedures for the assessment of pain in children and the provision of appropriate control.

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

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

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

All paediatric patients should have access to appropriately trained paediatric trained 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:

- 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.

Interim for Adoption from 01/10/13