NHS England

Standardising community health services

Core component descriptions

Supplementary guidance to the Medium term Planning Framework - delivering change together 2026/27 to 2028/29

February 2026

Publication reference: PRN02103

Core component descriptions

Further to NHS England » Standardising community health services, this guidance providers detailed descriptions of the core components of community health services (CHS) which account for the majority of CHS activity, including guidance on local and national reporting. For example, it clarifies which service/team is aligned with which core component description.

This document has been produced primarily for Integrated Care Boards to support strategic commissioning of Community Health Services, which they may wish to consider in immediate action to improve services, and in their longer-term reform agenda. This guidance should also support Community Health Service providers and their partners to improve delivery and alignment of local services.

This guidance does not change existing national reporting requirements and should be considered alongside existing user guidance for CHS activity data sets. Community health service activity should be recorded against the service or team type delivering it. Where a service or team does not fully align with the core component description, providers should select the one most closely aligned with their service provision.

CHS data collections by provider type are set out below and are kept under review. Please see the NHS Community Health Services Data Plan.

- All providers of publicly funded (NHS commissioned, local authority commissioned, and/or joint NHS and local authority commissioned) community health services should submit data to the CSDS.
- All providers of NHS commissioned and/or joint NHS and local authority commissioned community health services should submit data to the Community Services (CHS) SitRep.
- For providers submitting to Community FDF (pilot), this should include data on publicly funded community health services (NHS and/or NHS/local authority jointly commissioned and/or local authority commissioned).

Over the coming years we will work with ICBs and community service providers to align and develop national community health services activity, workforce, and financial data collections with this publication’s categorisation of services, until this is developed, there is no requirement to change reporting. The national data submission guidance in this Annex is therefore subject to further development over time.

Contents

Community musculoskeletal (MSK) services

MSK community services have a triage and therapies function to support the diagnosis and management of MSK conditions.

Description of the service

MSK services focus on the diagnosis and management of musculoskeletal conditions.

MSK conditions affect the joints, bones and muscles and sometimes associated tissues such as your nerves. They can range from minor injuries to long-term conditions. Symptoms can include pain, stiffness, limited movement, and consequent disability can affect people's ability to work, their quality of life and their independence.

Most community MSK services have:

- a triage function, often acting as an interface service between primary and secondary care to support diagnosis and optimise referrals, and/or
- a therapies function to rehabilitate those who have sustained an injury or are recovering from surgery, as well as to help people best manage long-term MSK conditions.

Models of delivery vary, and these functions can be integrated within one community MSK provider. Services are delivered in community settings, including health centres and clinics, with some integrating digital triage and/or therapeutic tools. Triage services access diagnostics such as MRI and have close working relationships with local secondary care services to support onward referral for those who need. Both group and individualised therapy is offered, collaborating with local mental health services and/or local charities, social enterprises and voluntary groups where able. Services may also offer additional, more specialist, services such as diagnostic ultrasound or corticosteroid injections. MSK services can play a key role in supporting people to stay in work.

Published guidance and specifications

- NHS MSK Improvement Framework: Outlines principles and actions to reduce community MSK waiting times while delivering optimal outcomes. NHS England
- Musculoskeletal physiotherapy service standards**:** Eight quality standards supporting the delivery of high-quality MSK physiotherapy services. CSP
- The GIRFT Further Faster Community MSK services Handbook**;** Guide reflects key components of community MSK delivery and provides checklists against which

practice can be assessed. Aligned to the defining principles and actions shared in the NHS Improvement Framework.

Who is the service for

- Community MSK services are for individuals with pain and disability associated with MSK conditions. The age of eligibility for accessing community MSK services varies depending on local arrangements.
- Referrals may be received from primary care, other community services, self-referral and secondary care.

Access and response times for first contact with service user

The community MSK Improvement Framework states that no priority patient should wait more than two weeks for assessment, priority patients are defined as:

- patients who have had recent surgery/procedure requiring rehabilitation and/or
- patients who have had a recent injury, fracture or dislocation requiring rehabilitation and/or
- patients with acute and/or complex needs with high levels of pain leading to significant loss of function and/or disturbed sleep, and/or an inability to work or undertake care responsibilities

The Medium Term Planning Framework asks systems to actively manage long waits for community health services, reducing the proportion of waits over 18 weeks and developing a plan to eliminate all 52-week waits.

Capabilities required at a population level

A well-resourced community MSK service is provided by a dynamic multidisciplinary team of clinicians with the knowledge, skills and capacity to sustainability deliver both triage and therapies functions to meet the needs of the local population. The therapies function should include robust provision of post-operative rehabilitation to meet the local populations needs.

This workforce must be well led and sustainably resourced with both robust governance and effective collaboration with partner service providers, organisations and users.

The leadership must be system focused and transformational across clinical and operational domains, able to collaborative with commissioners to undertake population health approach focused on optimising outcomes and reducing health inequalities.

The majority of this workforce are physiotherapists, including those working at an expert (consultant) and advanced practice level. The team may also include other Allied Health Professionals (AHPs) such as podiatrists or occupational therapists, and/or general practitioners with and extended role in MSK or sports and exercise medics. The clinical team is supported by operational and administrative staff.

It is recognised that a future strategic workforce diagnostic tool is necessary to support the planning and delivery of community MSK workforce models that are aligned with the population needs of the service.

Integration with wider health, education and social care system; services and agencies.

A system wide approach is required to support the MSK health of a population. Community MSK services must be integrated within this system working within a neighbourhood footprint.

Aligned to best practice guidance, coordinated pathways must be in place to enable referral between community MSK services and both primary and secondary care, as well as other community service lines. This also includes pathways to support the request and reporting of diagnostics. A collaborative approach to decision making is required with a shared approach to quality evaluation and improvement.

This collaborative approach also extends to mental health services and local charities, social enterprises and voluntary groups especially with regard to rehabilitation and supporting people to manage long term MSK conditions, and this also includes integration with initiatives to support people to remain or return to work.

Any specifics the service must meet for national requirements

Community MSK services must deliver care aligned with best practice guidance and pathways, with robust governance in place to support diagnostic referral and action, as well as timely appropriate personalised referral to secondary care services.

NICE Guidance:

- NICE NG 226 Osteoarthritis in over 16s diagnosis and management
- NICE NG 59 Low back pain and sciatic in over 16s assessment and management
- NICE NG 193 Chronic pain (primary and secondary) in over 16's
- NICE NG 157 Joint replacement hip knee shoulder
- NICE Musculoskeletal speciality topic suite: Musculoskeletal | Specialities | CKS | NICE

MSK pathways developed through GIRFT:

- GIRFT Orthopaedic pathways

- GIRFT Spinal surgery pathways
- GIRFT Rheumatology pathways

National data submission guidance

Record service or team referred to as ‘20 - Musculoskeletal Service’ (in table CYP102 Service or Team Type Referred To in CSDS, and table 6.b REFERRAL_SERVICE in FDF).

Ensure date of birth is recorded (in the MPI table CYP001 in CSDS, and table 5a.CARE_MPI in FDF).

In the CHS Sitrep, record adults under ‘(A) Musculoskeletal service’. CYP MSK waits to be recorded under therapy specific service lines in the SitRep e.g. physiotherapy service in the Sitrep.

Adult audiology

Audiology services assess and provide support for hearing loss, balance, tinnitus, and other auditory disorders.

Description of the service

Audiology services provide assessment, diagnosis and interventions for hearing and balance disorders with more complex medical referred to secondary care ENT services.

Service provision will vary dependent on commissioning arrangements, but may include:

- Hearing assessments
- Hearing aid provision & support, fitting of digital NHS hearing aids
- Aftercare – ensuring that patients receive appropriate auditory rehabilitation to provide ongoing support for their hearing loss needs, access to repairs, replacements and batteries and re-programming of hearing aids and follow on hearing reassessment
- Tinnitus management, assessment and support
- Information and signposting to supportive resources
- Balance assessments and vestibular rehabilitation
- Electrophysiology
- Referral pathways
    - Referral to ENT specialists or Audiovestibular Physicians when serious conditions are suspected
    - Referral to mental health services for emotional and mental wellbeing support for issues related to hearing loss including deaf identity and issues relating to tinnitus and hyperacusis
    - Referral to physiotherapy for vestibular rehabilitation

Services should be able to provide ear wax management including removal by microsuction or syringing for patients where earwax affects audiometry and/or hearing aid fitting. Services should support transition from paediatrics services from age 16 onwards (age cut off dependent on local arrangements) with the aim of completed transition for those from 18 years onwards, although transition to adult services should be supported over the timespan appropriate to the patient and for those with SEND longer transition/ support for this process up to age 25 may be required.

Who is the service for

Individuals aged 18 and over who experience hearing loss, tinnitus, or balance issues, including those with age-related hearing loss or specific needs like tinnitus management, and those requiring hearing aids, ongoing monitoring, or support for daily living.

Exclusion criteria:

- Sudden hearing loss (requires immediate ENT referral)
- Unilateral hearing loss (if suspected to be related to medical or surgical issues)
- Severe ear pathology (e.g., ear infections, ear trauma, or tumours)
- Medical conditions requiring specialist ENT or audio vestibular services, such as cochlear implantation or complex vestibular disorders.

Access and response times for first contact with service user

The national 6 six-week diagnostic waiting time standard is mandatory and must be applied for audiology diagnostic tests.

The operational standard states that less than 1% of patients should wait 6 weeks or more for a diagnostic test (see national data submission guidance).

The British Academy of Audiology Quality standards in paediatric audiology set a number of waiting time targets for diagnostics, treatment and communication.

The Medium Term Planning Framework asks systems to actively manage long waits for community health services, reducing the proportion of waits over 18 weeks and developing a plan to eliminate all 52-week waits.

Capabilities required at a population level

- Integrated data systems to support risk stratification and shared care planning
- Up to date knowledge and expertise in relevant health conditions and management
- Up to date knowledge of the available local services for community health
- Up to date knowledge of medicines for relevant health conditions and how (prescriber and prescription) they can be obtained
- Up to date knowledge of equipment and technologies (such as hearing aids) for relevant health conditions (in multiple settings) and suppliers
- Up to date knowledge of legal frameworks such as safeguarding requirements
- Specialist knowledge to be able to effectively triage calls and patients
- Adequate capacity within the community to respond to requests for face-to-face support

- Assessments carried out by/ under the supervision of senior staff that have the expertise to explain and discuss results with families.
- Clinical leadership skills and clinical supervision capability
- Direct referral pathways to ENT services
- Ability to work autonomously (but has awareness of when to seek further specialist support and advice)
- The Provider shall ensure the maintenance of full, accurate, legible and contemporaneous records (including of professional registration, service quality management and audits)
- All audiology services should be UKAS IQIPS accredited to ensure the appropriate level of clinical quality and standards, if not accredited services should have an active plan to gain accreditation within 3 years.
- Sufficient trained workforce to meet population need.
- Provision of population specific services – eg communication provision, BSL/languages
- Provision of estates and equipment appropriate for the diagnostic provision of all service areas

Integration with wider health, education and social care system; services and agencies. ￼

Audiology services require close working within multiple medical, education and social MDTs including;

- ENT services
- Audiovestibular Medicine Services
- General practice (provision of outcome reports and receipt of referrals)
- Community mental health and learning disability services

The workforce delivering this core component should align to Neighbourhood footprints as appropriate.

Any specifics the service must meet for national requirements

NICE guideline - Hearing loss in adults: assessment and management (nice.org.uk)

NICE guideline - Tinitus: assessment and management

NICE QS - Overview | Hearing loss in adults | Quality standards | NICE

Commissioning framework - HLCF.pdf (england.nhs.uk)

Hearing loss action plan - NHS England Report Template 1 - long length title

RNID stats - Our facts and statements - RNID

RCGP toolkit - Deafness and hearing loss toolkit: Introduction | RCGP Learning

British Society of Audiology – Tinnitus in adults practice guidance

NHS England - Action Plan on Hearing Loss (What Works Guides and Joint Strategic Needs Guidance)

British Society of Audiology - Guidance Documents

GIRFT NHSE – (when referring in to secondary ENT) Ear, Nose and Throat: referral guidelines (adult)

Maintain, or seeking to seeking to attain accreditation through United Kingdon Accreditation Service (UKAS) under the Improving Quality in Physiological Services (IQIPS) Framework.

British Academy of Audiology-Quality Standards for Adult Audiology

Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance framework

A number of professional societies and bodies, including the British Academy of Audiology, British Society of Hearing Aid Audiologists, the British Society of Audiology the Health and Care Professions Council (HCPC) and Academy of Healthcare Science provide professional standards and registration for audiologists.

Subject to local clinical arrangements, adherence to NHS England » Practising standards and clinical guidance – ear checks in residential special schools and colleges service

National data submission guidance

Record service or team referred to as ‘17 - Hearing Service’ (in table CYP102 Service or Team Type Referred To in CSDS, and table 6.b REFERRAL_SERVICE in FDF).

Ensure date of birth is recorded (in the MPI table CYP001 in CSDS, and table 5a.CARE_MPI in FDF).

In the CHS Sitrep, record under ‘(A) Audiology services’.

The service must complete and report all quality metrics to the Integrated Care Board (ICB) and NHS England (NHSE). The service must also meet the reporting and quality standards required by relevant external bodies such as UKAS, the Care Quality Commission (CQC), and the Medicines and Healthcare products Regulatory Agency (MHRA). This includes active participation in audit and monitoring of service outcomes, and compliance with data requirements.

Audiology diagnostic tests should also be recorded in the DM01 collection, which collects activity and waiting times data on audiology diagnostic assessments. The distinctions between audiology data collected on the CHS SitRep and DM01:

- The DM01 collects data on NHS-funded audiology diagnostic assessments across **all settings**, collecting activity and waiting times data, reporting on >6-week and >13-week waits in line with diagnostic 6-week standard. For more information on recording of audiology assessment in DM01 see Reporting Diagnostics Activity and Waiting Times(DM01) to NHS England for Audiology.
- The CHS SitRep collects information on all in scope **community providers** covering community audiology services, with service lines split into children and young people (CYP) and adult services and collects waiting times data up to >104-weeks.

Specialist tissue viability or wound care

The service may be called either a ‘Specialist tissue viability service’ or a ‘Specialist wound care service’.

Description of the service

Tissue viability and wound care services provide specialist clinical leadership, assessment, treatment, education and quality improvement to manage and prevent complex and chronic wounds across community to promote healing, reduce complications, and improve quality of life. This service is grounded in evidence-based practice and seeks to optimise health, reduce complications and avoid unnecessary hospital admissions. Services are delivered by tissue viability nurses (TVNs) and wound care-trained professionals in community settings including people’s homes, clinics, residential care and community inpatient care eg: mental health and general practice.

Key functions include:

- Assessment and diagnosis of wounds, including pressure ulcers, leg ulcers, diabetic foot ulcers, fungating wounds and surgical wounds.
- Development of personalised wound care plans and escalation pathways
- Specialist advice and treatment including debridement, advanced dressing selections, negative pressure wound therapy, wound infection management and antimicrobial resistance.
- Education and training for the wider workforce (e.g. community nurses, practice nurses, care home staff and in mental health settings) and embedding competencies and practice development in line with national guidance.
- Support for self-care and patient/carer empowerment.
- Advice and input into pressure ulcer prevention through skin integrity assessments, risk stratification and multi-disciplinary collaboration eg. falls, frailty teams, foot protection services and in multidisciplinary footcare teams.
- Auditing wound care practice, incident reporting and outcomes (e.g. prevalence audits, pressure ulcer reporting).
- Supporting implementation of standardised wound formularies and wound pathways.
- Reducing unwarranted variation in care, e.g. through leg ulcer pathway implementation.
- Providing expert advice to support commissioning, care planning, and system-wide strategies (e.g. pressure ulcer prevention plans, product selection policies).
- Working with ICSs, PCNs, and acute providers to ensure continuity of care and shared learning.

Outcomes: What to expect

The service aims to:

- Reduce the number and severity of wounds occurring
- Accelerate wound healing and reduce wound chronicity and help to reduce the need for amputations.
- Reduce variation in practice and improve clinical outcomes.
- Prevent avoidable harm, especially community-acquired pressure ulcers.
- Reduce hospital admissions related to infected or deteriorating wounds.
- Facilitate faster discharge
- Improve patient quality of life through reduced pain, odour, leakage, and social isolation.
- Enable evidence-based care, reducing the cost of ineffective or inappropriate interventions.
- Reduce the use of antibiotics
- Upskill the workforce
- Contribute to the development of the evidence base

Who is the service for

- Adults and children with complex or non-healing wounds (e.g. pressure ulcers, leg ulcers, post-surgical wounds, diabetic foot ulcers).
- Patients with recurrent or high-risk wounds.
- Individuals at risk of pressure damage due to immobility or frailty.
- Community-based patients with wounds requiring specialist assessment.
- People discharged from hospital with complex wound management needs.

Access and response times for first contact with service user

Referral Sources: community nurses, community children's nurses, general practice, care homes, podiatrists, hospital discharge teams, or self-referral (where locally agreed).

Response Times:

- Urgent wound assessment (e.g. suspected infection, rapid deterioration, Diabetic foot ulcer): Within 24hours.
- Routine referrals: Within 5–7 working days, triaged according to risk and complexity. (most services are Mon – Fri 9 – 5).
- Preventative assessments (e.g. for pressure ulcer prevention) within agreed local targets.

Capabilities required at a population level

- Wound prevalence and incidence data across care settings to understand need.
- Shared care records and digital wound assessment tools for monitoring and continuity.
- Shift clinical mindset to treat wound care, especially lower limb wounds, as a long-term condition—ensuring care pathways embed sustained healing support, systematic recurrence-prevention measures, and proactive community-level strategies to avert wound onset.
- Health equity analysis to identify underserved groups at higher risk (e.g. care home residents, people experiencing homelessness).
- Evidence-based formulary and local guidance aligned with national tissue viability policy.
- Data collection for wound healing rates, pressure ulcer incidence, and resource use.
- Integrated data systems to support risk stratification and shared care planning.
- Capabilities in addressing social determinants of health, including housing, transport, loneliness, and nutrition.
- Digital maturity to enable virtual wards, remote monitoring, and telehealth.
- Pathway implementation
- up to date knowledge of legal frameworks such as Mental Capacity act, Lasting Powers of Attorney, Advance Decision to Refuse Treatment, safeguarding requirements and The Children’s Act
- Specialist knowledge to be able to effectively triage calls
- Adequate capacity within the community to respond to requests for face-to-face support
- Communication skills and training for people with wounds,
- Clinical leadership skills and clinical supervision capability
- Ability to work autonomously, with the awareness of when to seek further specialist support and advice . including the need to establish pathways with Vascular and Orthopaedics and regular virtual MDT with such acute specialists.
- Approach to the prevalence of peripheral vascular disease (1 in 5 over 60yr olds) including ABPI and doppler, compression bandages, escalation policy.

Integration with wider health, education and social care system; services and agencies. ￼

The workforce delivering this core component should align to Neighbourhood footprints as appropriate.

The service operates as part of an integrated care approach, working closely with:

- Community nursing teams (district nurses, matrons)
- Midwives, community children's nurses, learning disability and dementia care teams)
- Multidisciplinary teams including general practice, practice nurses, social prescribers, social workers, occupational therapists, physiotherapists, nutrition and dietetics, mental health professionals, and voluntary sector partners.
- Virtual wards and hospital-at-home services.
- Education and housing services, especially where safeguarding, learning disability, or mental health needs are involved.
- Care homes, supported living, hospices, residential units and domiciliary care for monitoring and prevention.
- Podiatry, particularly for diabetic foot care.
- Acute care providers, to support wound care and surgical teams for escalation or follow-up.
- Safeguarding teams, where pressure damage may be a concern.
- Procurement and medicines optimisation teams to ensure cost-effective use of equipment and dressings and antimicrobial stewardship.
- Social care systems for provision of equipment
- VCSE providers often for equipment provision
- Microbiology teams
- Moving and handling teams
- Harm Free care teams
- Hospital to home
- Pharmacists
- Patient Safety Team
- other multidisciplinary specialist teams
- rapid response team / urgent community response / virtual ward
- social care services – both in hours and out of hours
- urgent and emergency care services, including NHS 111 and ambulance services
- providers of services for individuals with long-term conditions
- local authority services and education
- health visiting/school health nursing
- Fire service

Any specifics the service must meet for national requirements

Tissue viability and wound care services must align with:

- NHS England's National Wound Care Strategy Programme (NWCSP) for lower limb, pressure ulcer, and surgical wound care.

- NICE guidelines, including CG179 (pressure ulcer prevention), CG147 (lower limb ulcers), and NG19 (diabetic foot problems).
- Diabetes Commissioning Support | England, UK | Improving Diabetic Foot Care
- CQUIN or other quality improvement frameworks, where relevant.
- CQC fundamental standards and safeguarding responsibilities.
- Locally agreed formularies and wound care pathways developed in line with evidence-based recommendations.
- Workforce competency frameworks, ensuring staff are trained and supported to deliver high-quality wound care.

National data submission guidance

Record service or team referred to as ‘43 - Tissue Viability Service’ (in table CYP102 Service or Team Type Referred To in CSDS, and table 6.b REFERRAL_SERVICE in FDF).

Ensure date of birth is recorded (in the MPI table CYP001 in CSDS, and table 5a.CARE_MPI in FDF).

NB: Non-specialist wound care should be recorded under the service/team type it is delivered by e.g. district nursing. Where it is the primary or other reason for referral it should be recorded as such (using ‘70 – Wound Care’. For primary referral reason: in table CYP101 Service or Team Referral in CSDS, and table 6a. REFERRAL in FDF. For ‘other reason for referral’: in table CYP103 Other Reason for Referral in CSDS).

In the CHS Sitrep, record under ‘(A) Nursing and Therapy support for LTCs: Tissue viability’.

Community nursing

Adult Community Nursing, sometimes referred to as district nursing.

Description of the service

Adult community nursing services provide proactive, personalised, and holistic nursing care in people's homes (including residential and supported living homes) and community settings. The service supports individuals with complex health needs, long-term conditions, and those nearing the end of life. The core purpose is to:

- Deliver community healthcare in the person's own home
- Prevent avoidable hospital admissions.
- Facilitate early discharge from hospital.
- Promote health, independence, and dignity.
- Address social determinants of health through advocacy and integrated support.
- Role in patient safety (national patient safety strategy and PSIRF), patient experience, engagement and complaints management.

Core components include:

- Assessment and review of health conditions, development of person-centred care planning with oversight of clinical interventions
- Prevention and management of deterioration of conditions ie nutrition, tissue viability, safeguarding and frailty
- Wound care e.g., leg ulcers, pressure ulcers, some which maybe complex, in liaison with Specialist Tissue Viability and Wound care services.
- Long-term condition management (e.g., diabetes, COPD, heart failure, neurological, spinal diseases and cancer).
- End-of-life and palliative care.
- Bowel and bladder care (e.g., catheter management, continence assessments and management of complex neurological intervention and support).
- Support required in the community post-operative/ following surgery.
- Medication management, including IV therapy, symptom and pain management
- Management of technology dependency
- Consideration of nutritional screening in line with NG32/QS 24.
- Nutritional support interventions (e.g., PEG, NG feeding) Underlying swallowing difficulties that necessitate tube feeding require specialist assessment and management by speech and language therapists.
- Crisis intervention and rapid response to health deterioration.
- Transition from children and young people's community services

- Referrals to appropriate long-term health and social care support packages ie Care Act or Continuing Healthcare
- Lead or be part of an MDT approach to long term care assessments and reviews.

The service is delivered by registered nurses, district nurses (with SPQ), nursing associates, healthcare support workers, working alongside Allied health professionals, Social workers and advanced clinical practitioners including Community Consultant Nurses.

Outcomes: What to expect

Community nursing services aim to deliver the following outcomes:

- Improved health outcomes and independence through better self-management of conditions.
- Reduced emergency admissions and re-admissions via early intervention.
- Safe, dignified end-of-life care in the person's preferred place of death.
- Improved patient experience and satisfaction by receiving care at home or Adults 18+ in residential schools or care settings up to 25 years of age.
- Equitable access to care across geographic and demographic boundaries.
- Enhanced safeguarding through early identification of risk and partnership with statutory services.

Who is the service for

- Adults aged 18+ with complex nursing needs in the community and those young people 16-18 that choose to be cared for in an adult service.
- People who are housebound due to illness, disability, or frailty.
- Individuals needing palliative or end-of-life care.
- Patients recently discharged from hospital requiring ongoing care.
- People at risk of deterioration who could avoid admission with early intervention.
- Carers requiring training or support to provide delegated care safely
- Joint working with social care providers including education, training and competency assessment.

Access and response times for first contact with service user

Referral Routes: general practice, hospital discharge teams, NHS 111, Urgent Community Response (UCR), continuing healthcare, social care, significant range of community services including mental health services, VCSE sector services, ambulance services.

Response Timeframes:

- Urgent care (UCR): Within 2 hours.
- Short-term needs (post-discharge): 2 hours+ – 48 hours.
- Routine referrals: within 5 working days depending on clinical need and prioritisation.
- End-of-life patients and safeguarding concerns are prioritised for same-day response.

Capabilities required at a population level

To deliver this service effectively at scale, systems need:

- Population health intelligence to identify high-risk individuals and areas of high demand.
- Integrated data systems to support risk stratification and shared care planning, ideally based on an integrated EPR.
- Access to medicines in the community
- Workforce planning tools to deploy nursing teams according to local population need.
- Capabilities in addressing social determinants of health, including housing, transport, loneliness, and nutrition.
- Digital maturity to enable virtual wards, remote monitoring, and telehealth.
- Knowledge and expertise in relevant health conditions and management
- Knowledge of the available local services for community health
- Knowledge of medicines for relevant health conditions and how (prescriber and prescription) they can be obtained
- Knowledge of equipment for relevant health conditions (in multiple settings) and suppliers
- Up to date knowledge of legal frameworks such as Mental Capacity act, Lasting Powers of Attorney, Advance Decision to Refuse Treatment, safeguarding requirements and The Children’s Act
- Specialist knowledge to be able to effectively triage calls
- Adequate capacity within the community to respond to requests for face-to-face support
- Communication skills and training for people with complex long-term conditions,
- Clinical leadership skills and clinical supervision capability
- Ability to work autonomously (but has awareness of when to seek further specialist support and advice)
- Education and training on the importance of providing adequate nutrition

- Up to date knowledge of legal frameworks such as Mental Capacity act, Lasting Powers of Attorney, Advance Decision to Refuse Treatment, safeguarding requirements, learning disabilities training (e.g. Oliver McGowan Mandatory Training) and The Children's Act.

Integration with wider health, education and social care system; services and agencies.

Community nursing services work as part of:

- Integrated Neighbourhood Teams aligned with PCNs, ICBs, and local authorities.
- The workforce delivering this core component should align to Neighbourhood footprints as appropriate.
- Multidisciplinary teams including general practice, specialist nurses, social prescribers, social workers, allied health professionals (including occupational therapists, physiotherapists and speech and language therapists), nutrition and dietetics, mental health professionals, and voluntary sector partners.
- Virtual wards and hospital-at-home services.
- Education and housing services, especially where safeguarding, learning disability, or mental health needs are involved.
- Residential care homes, supported living, and domiciliary care agencies. Collaboration is enabled through regular joint case reviews, multidisciplinary team meetings, and joint commissioning.

Any specifics the service must meet for national requirements

The service must comply with:

- NHS England Standards and Service Specifications.
- Urgent Community Response (UCR) 2-hour response standard (part of the Ageing Well programme).
- CQC regulations for quality and safety.
- Safeguarding responsibilities under the Care Act (2014).
- Equality Act (2010) duties to provide equitable access.
- Digital standards including use of shared care records (ShCR) and NHS number as the identifier.
- Workforce training and credentialing standards, including those outlined by the Queen's Institute for Community Nursing (QICN) and NHS England for district nursing.
- Community Care Pressure Ulcer Surveillance using Model Health System Metrics *(draft)* including SNOMED codes.

- Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition NICE CG32
- Nutrition support in adults NICE QS24 Overview, Nutrition support in adults Quality standards

National data submission guidance

Record service or team referred to as ‘12 - District Nursing Service’ (in table CYP102 Service or Team Type Referred To in CSDS, and table 6.b REFERRAL_SERVICE in FDF) or more appropriate specific service type where delivered by community nursing e.g. Diabetes Service, Cardiac Service, Long Term Conditions Case Management Service.

Ensure date of birth is recorded (In the MPI table CYP001 in CSDS, and table 5a.CARE_MPI in FDF).

In the CHS Sitrep, record under ‘(A) Community nursing services’ or more appropriate service type where delivered by community nursing e.g. Nursing and Therapy support for LTCs: Heart failure.

Intermediate care (rehabilitation, reablement and recovery) services

Intermediate care – which may be health or social care, or a combination of health and social care – is an umbrella term for short-term, community-based services that help people recover and rebuild their independence. Also known as rehabilitation, reablement and recovery services, these may be home-based or community bed-based, provided on a step-up or step-down basis, and integrated with wider services.

Description of the service

Typically lasting no longer than six weeks, intermediate care aims to help people recover and rebuild their independence and help reduce or eliminate their need for further healthcare and/or long-term social care.

Intermediate care is tailored to a person's needs and usually includes a combination of therapy-led rehabilitation and/or reablement assessments and interventions, as well as other assessments and interventions to aid recovery. Registered therapists (allied health professionals, such as physiotherapists, occupational therapists and speech and language therapists) lead rehabilitation and reablement, and unregistered support workers (health and social care) play a key role in delivery. A range of other staff groups may also be deployed flexibly as necessary to support the recovery process, such as doctors, nurses, other allied health professionals, pharmacy professionals, specialists, care workers, social workers and housing/homelessness workers.

Delivery of intermediate care takes place in a person's usual place of residence (e.g. own home or care home if they are a resident) in line with the home-first principle, and/or in a community bed-based setting (e.g. community hospital, care home or other bed-based facility). Referrals may be on a step-up basis from the community (e.g. general practice, community health services or adult social care), or on a step-down basis from inpatient settings or hospital at home (virtual ward) services.

For people receiving intermediate care, expected outcomes are based on what matters to them and may include improved movement, function, communication, cognition, wellbeing, skills and confidence (leading to increased independence and reduced reliance on unpaid carers). For health and social care services, expected outcomes may include reduced demand for long-term social care (both home care and care home packages), reduced demand for further healthcare (including acute hospital admissions and readmissions), and reduced delayed discharges from inpatient settings.

Who is the service for

Intermediate care is for adults (aged 18 years or over) living in the community or recently discharged from inpatient settings or hospital at home (virtual ward) services who have greater needs than usual and the potential to benefit from rehabilitation, reablement and recovery services. Whether a person is offered intermediate care – and the type, intensity and duration of care they receive – is based on an initial assessment of their needs and regular reviews of their progress.

Most people receiving intermediate care are older adults with frailty and/or complex needs, but younger adults may also benefit. Equity of access and provision is a guiding principle, ensuring intermediate care is available to all individuals who need it regardless of condition, characteristic, need or circumstance, and irrespective of whether they go on to receive funded or self-funded long-term care. This may include (but is not limited to) people with mild cognitive impairment, dementia, delirium, palliative care and end of life care needs, mental health conditions, learning disabilities, autism, and obesity (including people receiving bariatric care). It may also include (but is not limited to) people living in care homes, high-risk settings such as prisons and unsafe housing, and those experiencing homelessness or at risk of homelessness.

Intermediate care may benefit some people with low to moderately complex rehabilitation needs requiring specialist expertise. This may include situations where reablement is needed alongside specialist input to support a person at home, or where a community bedded service is needed to support a person transitioning back into the community from specialist rehabilitation services. In these cases, rehabilitation with specialist input will often be required beyond the intermediate care period to meet ongoing needs.

Intermediate care is not suitable for people with highly complex specialised or specialist rehabilitation needs. However, transfers from specialised rehabilitation services – to specialist rehabilitation services – to intermediate care rehabilitation services may occur as rehabilitation complexity reduces.

Individuals should be matched to the most appropriate rehabilitation service using a standardised stratification process which identifies acuity, complexity, dependency and intensity of needs. Relevant national/local standards, service specifications and clinical polices should be followed.

Access and response times for first contact with service user

Whilst there are no national access/response times, people should be assessed for and (if needed) receive intermediate care in a timely manner. Many systems aim to provide intermediate care services within one (and no more than two) days.

Intermediate care should be provided to a person only for as long as it is required, usually for a maximum of six weeks. The type, intensity and duration of intermediate care a person receives is based on an initial assessment of their needs and regular reviews of the progress they make towards reaching their goals as set out in their individual plan. The plan should be developed promptly and reviewed in conjunction with the person and, where appropriate, their family members and carers.

Where possible, a person starting intermediate care in a community bed-based setting should be discharged at a suitable point to continue intermediate care in their own home (usual place of residence), provided it is a suitable and safe environment.

Capabilities required at a population level

Demand and capacity planning

- Joint demand and capacity planning across integrated care boards and local authorities as part of wider planning, ensuring the right balance of home-based/bed-based and step-up/step-down capacity, and adequate workforce and equipment.
- Population health management data and analytics to forecast demand based on needs across different population cohorts, rather than solely on historic activity.
- Joint action planning across integrated care boards and local authorities to close gaps between demand and capacity and respond to surge and winter pressures.

Strategic partnerships, commissioning and contracting

- Involvement of wider partners (e.g. social care providers) – including from the independent and voluntary sectors – as strategic partners, not just delivery partners.
- Joint commissioning arrangements across health and social care that focus on joint outcomes and productivity, underpinned by pooled NHS and local authority budgets through the Better Care Fund, with clear governance and accountability.
- Sustainable, longer-term contracting should replace short-term spot purchases, where feasible. It is critical to stratify services to meet individuals’ needs, ensuring staffing/skill-mix reflect the range of requirements across acuity, complexity, dependency and intensity of needs, with flexibility to enhance services within contracting arrangements where possible.

Optimisation of resources

- Demonstration by integrated care boards and local authorities that their plans for the use of the Better Care Fund represent value for money, improve overall productivity and will be effectively managed to deliver these benefits.
- Workforce planning and training to ensure sufficient therapy workforce numbers and skill-mix – for both registered therapists (allied health professionals, such as physiotherapists, occupational therapists and speech and language therapists) and unregistered support workers (health and social care).
- Therapy-led, multi-disciplinary team delivered rehabilitation and/or reablement (i.e. professional oversight by registered therapists who may be employed by any organisation), with appropriate medical oversight (e.g. by geriatricians or GPs).

Use of data and technology

- System-wide visibility of real-time data that is embedded into day-to-day operations across health and social care, ensuring a single version of the truth.
- Data-driven measurement of performance, quality, outcomes and experiences (both qualitative and quantitative) to evaluate impact and guide continuous improvement.
- Digital tools for remote assessment, delivery, monitoring and advice, where suitable.

Integration with wider health, education and social care system; services and agencies

Intermediate care services may be commissioned by the NHS and/or by local authorities, with delivery through a range of health and social care providers across the NHS, local government, independent and voluntary sectors. Where intermediate care requires a combination of health and social care, it is best practice for it to be planned, commissioned and delivered in an integrated way, in line with the intermediate care framework for rehabilitation, reablement and recovery following hospital discharge and wider related policies.

Transfers between intermediate care, urgent community response and hospital at home (virtual ward) services should be seamless and there can be value in integrating service delivery as part of the development of neighbourhood health services, with these services complementing each other. Intermediate care is typically provided for up to six weeks, with a focus on rehabilitation, reablement and recovery to maximise independence; while urgent community response offers rapid urgent care lasting a couple of days to prevent an acute hospital admission; and hospital at home delivers acute hospital-level care in a person's home, typically for up to two weeks, as a substitute for an acute inpatient stay. Intermediate care may be provided to promote recovery after urgent or acute needs have been met through urgent community response or hospital at home (virtual ward) services respectively.

The workforce delivering this core component should align to Neighbourhood footprints as appropriate.

Any specifics the service must meet for national requirements

National requirements are covered within the following guidance:

- Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge – good practice guidance for integrated care boards to support their work with health and social care partners to plan, commission and deliver step-down (post-discharge) intermediate care.
- Community rehabilitation and reablement model – good practice guidance for integrated care boards on community rehabilitation and reablement provided as part of step-down (post-discharge) intermediate care.
- Care and support statutory guidance – requirements for local authorities, including in relation to the provision of intermediate care.
- Roles and principles of reablement – briefing for those working in reablement or commissioning it on the role and principles of reablement in the social care sector.
- Better care fund guidance – guidance setting out the purpose, funding and conditions for the Better Care Fund.
- Further national requirements are set out in guidance for discharge from acute and community inpatient settings.

National data submission guidance

Providers of NHS-funded and/or NHS/local authority jointly-funded **bed-based** intermediate care must submit community bed data on a range of areas to the weekly intermediate care data collection and annual community bed audit.

Providers of NHS-funded and/or NHS/local authority jointly-funded intermediate care should submit data on referrals into intermediate care and care contacts to the monthly community services data set.

Community health services providers of intermediate care should submit data on how long people have been on the waiting list for intermediate care to the monthly community health services sitrep.

NHS acute trusts with a type 1 A&E department must submit data on discharges and delayed discharges into intermediate care to the weekly acute discharge sitrep.

Local authorities must submit client-level data on events involving requesting and/or receiving local authority-funded and NHS/local authority jointly-funded intermediate care to the quarterly adult social care client level data product.

For providers submitting to the community FDF (pilot), this should include data on NHS-funded and NHS/local authority jointly-funded intermediate care.

Discharge to assess approach

The discharge to assess approach supports timely discharge from acute and community inpatient settings, by arranging for people to receive assessments for most onward care and support needs (if required), after they have been discharged to their usual place of residence (in line with the home-first principle), or to a community bed-based setting (where appropriate).

Description of the approach

Discharge to assess is when people who are ready to leave acute and community inpatient settings, and who are likely to need onward care and support, are discharged in a timely manner, typically to their usual place of residence (e.g. own home or care home if they are a resident), to receive assessments for most onward care and support needs. Under this approach, any assessment carried out while someone is still in an inpatient setting will generally focus on determining the most appropriate discharge pathway and destination, identifying any immediate care and support requirements (i.e. where it would not be safe or appropriate for someone to be discharged without services being in place to meet those immediate needs) and identifying who will then be responsible for assessing further care and support needs.

Although originally introduced to ensure long-term care needs and financial assessments take place out of acute hospital settings, discharge to assess now reflects a broader understanding that most assessments for post-discharge care and support, including assessments for short-term services such as intermediate care, should be undertaken out of the acute hospital environment.

When planning discharge from inpatient settings, the home-first principle should be applied. This means prioritising discharge to a person’s usual place of residence, with discharge to a community bed-based setting (e.g. community hospital, care home or other bed-based facility) only when it is clearly the most appropriate option to meet the person’s needs. Whilst home-first guides discharge planning, it is a much broader principle, driving efforts to support people (wherever possible and appropriate), to remain in – or return as quickly as possible to – their usual place of residence. The home-first principle underpins a range of services that help people maintain or regain independence and prevent avoidable hospital or care home admissions.

The hospital discharge and community support statutory guidance defines four discharge pathways (0 to 3). Most people are discharged via pathway 0 (simple discharges), returning to their usual place of residence without any new or increased needs. Those with new or increased needs follow discharge pathways 1 to 3 (complex discharges). Applying the home-first principle means the home-based pathways (pathways 0 and 1) are prioritised where possible.

A person may receive intermediate care on pathway 1 (home-based) or 2 (bed-based) to actively promote their recovery, helping to reduce the likelihood of acute hospital readmission and/or need for long-term social care. Pathway 3 is used in the rare cases when a person is likely to require a permanent care home placement for the first time due to highly complex needs. A short-term arrangement may be established initially to allow time for the person to settle and stabilise, whilst long-term care assessments are completed, and decisions are made regarding the permanent placement. To minimise multiple moves, this short-term arrangement should, where possible, be delivered in the same location as the anticipated permanent placement.

Community bedded care should not be used simply to free up an acute hospital bed or because home-based care is not available. Wherever possible, people should be discharged to their usual place of residence (in line with the home-first principle).

Regardless of pathway, long-term care needs and financial assessments (if required) should be initiated as a person recovers or stabilises and fully completed once a point of recovery or stability has been reached so it is possible to make an accurate assessment of ongoing needs.

For people discharged, expected outcomes may include reduced risk of inpatient deconditioning (leading to improved outcomes across multiple areas). For health and social care services, expected outcomes may include reduced delayed discharges from acute and community inpatient settings, and improved flow (leading to upstream benefits in emergency departments and ambulance services). Further benefits are expected if intermediate care is provided, including reduced risk of acute hospital readmission, reduced demand for long-term social care and reduced reliance on unpaid carers.

Who is the approach for

The discharge to assess approach is used for adults (aged 18 years or over) who no longer meet the criteria to reside in acute or community beds and are discharged on pathways 1 to 3 due to new or increased needs. Most people discharged using this approach are older adults with frailty and/or complex needs, but younger adults may also benefit.

Access and response times for first contact with service user

Whilst there are no national access/response times, guidance sets out key expectations for implementing the discharge to assess approach and applying the home-first principle to discharge, including:

- Start discharge planning early from admission (or pre-admission for those undergoing elective procedures). Involve the person and, where appropriate, their family members and carers. Set an expected discharge date and promptly identify and refer to the care transfer hub those expected to require discharge on pathways 1 to 3.
- Ensure safe and timely discharge – across all discharge pathways, as soon as the person no longer requires care in the acute or community inpatient setting.
- For those on pathways 1 to 3, use the care transfer hub to determine of the most appropriate discharge pathway , take into account of information from ward staff and in discussion with the person and, where appropriate, their family members and carers. The care transfer hub should also plan how to meet immediate post-discharge care and support needs and ensure a safety and welfare check takes place on the day of discharge to confirm those immediate needs are met.

Further expectations apply if intermediate care is provided following discharge, including that people should be assessed for and (if needed) receive the services in a timely manner.

Capabilities required at a population level

System leadership and joint accountability

- An executive lead, employed by any partner in the system, to provide strategic oversight and ensure NHS bodies and local authorities cooperate with one another in relation to discharge.
- A single coordinator, employed by any partner in the system and reporting to the executive lead, to develop a shared system view of discharge, hold all parts of the system to account and drive the actions that should be taken as a system to address shared challenges.
- Clear governance and accountability structures across health and social care to oversee the joint planning, commissioning and delivery of discharge services.

Clinical review and seven-day working

- Early discharge planning from admission (or pre-admission for those undergoing elective procedures), including identifying at the earliest opportunity, those likely to have new or increased needs requiring care and support following discharge (i.e. those expected to require discharge on pathways 1 to 3).
- Twice daily clinical review of inpatients to determine those who no longer meet the criteria to reside and should therefore be discharged.
- Seven-day working to improve weekend discharge rates.

Care transfer hubs and case management

- Care transfer hubs, bringing together multi-disciplinary and multi-agency teams across sectors, to coordinate discharges via pathways 1 to 3, using a triage process to determine the most appropriate discharge pathway based on information from ward staff.
- Application of case management for people on pathways 1 to 3 to support their journey – from discharge planning through to discharge, ensuring immediate post-discharge care and support needs are met. In mature systems, case management may extend to the post-discharge recovery period and long-term care assessments (if required).

Use of data

- System-wide visibility of real-time data that is embedded into day-to-day operations across health and social care, ensuring a single version of the truth.
- Data-driven measurement of performance (including length of discharge delays based on discharge-ready-date data, and reasons for discharge delays), quality, outcomes and experiences (both qualitative and quantitative) to evaluate impact and guide continuous improvement.

Legal compliance

- Clear policies and procedures aligned to legal frameworks across health and social care covering mental capacity, safeguarding, carers (including young carers), patient choice, housing, homelessness, NHS continuing healthcare, NHS-funded nursing care, and local authority-funded care.

Further capabilities are required in relation to intermediate care.

Integration with wider health, education and social care system; services and agencies

NHS bodies and local authorities have a legal duty to cooperate to promote health and welfare, including in relation to hospital discharge as set out in the hospital discharge and community support statutory guidance. To fulfil this duty, they should jointly agree discharge models that best meet local population needs and are affordable within locally available budgets. This collaborative approach should be taken within the context of integrated care systems and neighbourhood health development to ensure discharge processes and services are joined up or integrated (where appropriate) across local areas.

Care transfer hubs may support the duty to cooperate by acting as coordination points for discharges via pathways 1 to 3, bringing together multi-disciplinary and multi-agency teams – including health, social care, housing and voluntary sector partners – with strong links into onward health and social care providers. Effective collaboration across professional and organisational boundaries is key to minimise discharge delays and mitigate risks, preventing overly cautious or unsafe decisions. Social workers are instrumental in this process, helping people, families and carers to make informed choices by weighing up the risks and benefits of options.

The workforce delivering this core component should align to Neighbourhood footprints as appropriate.

Any specifics the approach must meet for national requirements

National requirements are covered within the following guidance:

- Hospital discharge and community support statutory guidance – requirements for NHS bodies and local authorities in relation to discharge from acute and community inpatient settings.
- Discharging people at risk of or experiencing homelessness guidance – guidance for staff in care transfer hubs and others involved in discharge planning (including NHS, local authority, housing and other partners) in relation to discharging people at risk of or experiencing homelessness.
- Acute discharge sitrep technical specification – requirements for NHS acute trusts in relation to the collection of data on discharge.
- Discharge ready date guidance – requirements for NHS acute trusts in relation to the collection of discharge-ready-date data.

Further national requirements are set out in guidance for intermediate care.

Palliative care and end of life care – adults

Approximately 1% of the population (over 500,000 people) die each year, of which 0.75% - 0.9% could reasonably be considered to have palliative care and end of life care needs. Palliative care (Adults) is an approach that improves the quality of life of people from the age of 18 and their families facing the difficulties associated with life-threatening or life-limiting illness. End-of-life care is provided to people who are likely to be in the last 12 months of life. Both include care of the dying.

Description of the service

People with palliative and end-of-life care needs should be supported by a whole system approach, meaning care and support is personalised and provided by the right professional, at the right time, in the right place, including out of hours. People's palliative care needs (physical, psychological, social and spiritual / cultural) needs and complexity can fluctuate towards the end-of-life, requiring an agile and flexible model of care. Care is provided through universal care providers including primary, community, acute and urgent care services, as well as specialist-level palliative care services when needed.

PCEoLC is delivered in all settings in the community, including:

- People's usual place of residence:
- People's own homes
- Care homes
- Nursing homes
- Inpatient units:
    - Community hospitals
    - Hospices
    - Secure units
    - Hostels

Typical universal activities include but are not limited to:

- Symptom assessment and management, holistic needs assessment and support, personalised care and support planning, including advance care planning
- Family / carer pre and post bereavement support
- MDT provision of care, including care coordination
- Inpatient provision, including any respite care provided by hospices
- Rehabilitation
- Typical **specialist level palliative care** activities include, but is not limited to:
- specialist knowledge (specialist consultant and specialist nursing services as a minimum) to assess and manage physical, psychological, social, religious and

spiritual needs to reduce symptoms, suffering and distress, thereby maintaining and improving quality of life

- supporting analysis of complex clinical decision-making challenges where medical and personal interests are finely balanced by applying relevant ethical and legal reasoning alongside clinical assessment
- providing specialist advice, support, education and training to the wider care team who are providing direct core level palliative care to the person.

Who is the service for

People aged 18 and older with progressive, life-threatening illness and those likely to be in the last 12 months of life.

Those important to the person, including spouses, partners, children, friends and informal carers are also supported.

End of life Care service refers to care that helps all those likely to be in the last 12 months of life with advanced, progressive and terminal conditions to live as well as possible until they die. It enables the supportive care needs of both the individual and the family to be identified and met through the last phase of life and into bereavement. It includes the physical care, management of pain and other symptoms and provision of psychological, social care, spiritual and practical support.

Specialist Palliative Care Service includes care and support delivered by a multi-disciplinary team with the requisite qualifications, expertise and experience to improve quality of life for **people with progressive life-limiting illness with the most complex needs** (for example complex symptoms, rehabilitation or family situations and ethical dilemmas regarding treatment and other decisions). Input from Specialist Palliative Care professionals must be based on the person’s needs and not their diagnoses.

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care is often delivered in conjunction with other therapies that are intended to prolong life, and includes those investigations needed to better understand and manage clinical complications. Palliative care can be provided by a range of health and social care staff and may be done alongside treatment intended to reverse particular conditions.

Access and response times for first contact with service user

Dependent on local arrangements, but likely to include self-referral or referral from another provider (including but not limited to general practice, hospice team, care home, community/district nursing, condition-specific service or hospital discharge)

Initial assessment and triage of need to be undertaken within 24 hours of referral or a change in need being identified.

Capabilities required at a population level

Required capabilities include:

- Prescribing and administering controlled drugs
- Administering IVs
- Setting up and maintaining syringe drivers
- Care of advanced interventions such as long-term (non and invasive) ventilation, tracheostomies, TPN, PEGs and oral secretion management
- Therapeutic and rehabilitative palliative care, maximising independence and social participation in line with wishes and preferences (e.g. physiotherapy, speech and language therapy, occupational therapy etc)
- Advanced communication skills
- Care and support planning, including advance care planning
- Knowledge and expertise in the assessment and management of palliative care and end of life care needs, including symptom management
- Knowledge of the available relevant local services for palliative care and end of life care
- Knowledge of medicines for PCEoLC and how (prescriber and prescription) they can be obtained
- Knowledge of equipment for PCEoLC needs (in multiple settings) and suppliers
- Knowledge and competent use of the local personalised care and support planning systems, including Personal Health Budgets, and documents including symptom management and advance care plans
- Up to date knowledge of legal frameworks such as Mental Capacity act, Lasting Powers of Attorney, Advance Decision to Refuse Treatment, safeguarding requirements, learning disabilities training (e.g. Oliver McGowan Mandatory Training) and The Children's Act.

Integration with wider health, education and social care system; services and agencies.

In the delivery of an integrated service, interdependencies exist between the specialist-level palliative care services and primary and community providers:

- general practice, district nurses and out of hours services
- other multidisciplinary specialist teams, including Allied Health Professionals
- rapid response team / urgent community response / virtual ward
- adult social care services – both in hours and out of hours
- providers of domiciliary care and residential and nursing homes
- other providers of PCEoLC services: statutory and voluntary
- providers of acute care
- urgent and emergency care services, including NHS 111 and ambulance services
- providers of services for individuals with long-term conditions
- local authority services
- Community mental health and learning disability services.

Overall expectations include working in partnership to:

- Undertake assessments and personalised care and support planning, including advance care planning
- Undertake multidisciplinary teamworking

The workforce delivering this core component should align to Neighbourhood footprints as appropriate.

Any specifics the service must meet for national requirements

NICE Guidelines:

- End of life care for adults: Service delivery (NICE NG142): Requires a coordinated, malpractitioner approach, which includes out of hours care.
- End of Life care for adults (NICE QS13)
- Care of dying adults in the last days of life (NICE NG31): requires care that is coordinated between health and social care practitioners within and across different services and organisations.

NHS England:

- Palliative and End of Life Care. Statutory Guidance for Integrated Care Boards
- Specialist palliative and end of life care services. Adult service specification
- Universal Principles for Advance Care Planning

National Palliative and End of Life Care Partnership

- Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026

National data submission guidance

Record service or team referred to (in table CYP102 Service or Team Type Referred To in CSDS, and table 6.b REFERRAL_SERVICE in FDF).

as: ‘14 - End of Life Care Service’ - see definition above.

or ‘47 - Specialist Palliative Care Service’- see definition above.

Ensure date of birth is recorded (in the MPI table CYP001 in CSDS, and table 5a.CARE_MPI in FDF).

Palliative care and end of life care – 24 hours a day, 7 days a week access to specialist advice for professionals

Specialist advice for palliative care and end-of-life care for professionals supporting and caring for people of all ages with palliative care and end of life care needs, 24 hours a day, 7 days a week.

Description of the service

Access to specialist advice for palliative care and end-of-life care for professionals supporting and caring for people of all ages with palliative care and end of life care needs, 24 hours a day, 7 days a week. The service:

- provides a telephone number which can be widely share and promoted with appropriate professionals and relevant agencies
- clearly sets out any eligibility criteria based on patient need, and avoids ‘only those known’ to the service
- has escalation procedures in place where urgent care or very specialist advice is required e.g. escalating challenging communication issues to speech and language therapists for specialist input,
- has ambulance or transfer processes with appropriate workforce in place for managing i.e., on-call senior managers
- can escalate to on-call specialist palliative care consultants for complex calls where the service is staffed by nurses or other professionals

24/7 access may include:

- Access to medicines
- Capacity within the MDT to provide specialist care and support on a 24/7 basis, including support to wider teams
- Specialist medical and nursing support

Provides access to a qualified healthcare professional, available 24 hours a day, 7 days a week, who:

- has access to the person's health and care records and advance care plan, and,
- has the right level of competence to make informed decisions about changes to care
- has access to more senior specialist advice whenever required
- has information about local systems and services
- works in partnership with the person, their carers and those important to them
- provides advice for all professionals providing PCEoLC care (including hospices and care homes), general practice, local agencies, and trained caregivers with concerns

Advice services for carers and people close to the person can be incorporated into the above but in many areas the specialist palliative care 24/7 advice service is for professionals only.

Who is the service for

Professionals supporting people of all ages with progressive, life-threatening illness and those likely to be in the last 12 months of life.

Access and response times for first contact with service user

Dependent on local arrangements, but should be achieved at the first call, with provision for stacking calls possible.

All calls triaged and linked to existing systems (e.g. Single Point of Access, 111) as appropriate, with patient-facing response times dependent on the required action.

Capabilities required at a population level

Required capabilities include:

- Specialist knowledge to be able to effectively triage calls
- Adequate capacity within the community to respond to requests for face-to-face support
- Access to medicines in the community
- Knowledge and expertise in the assessment and management of palliative care and end-of-life care needs, including symptom management
- Knowledge of the available relevant local services for palliative care and end of life care
- Knowledge of medicines for PCEoLC and how (prescriber and prescription) they can be obtained
- Knowledge of equipment for PCEoLC needs (in multiple settings) and suppliers
- Knowledge and competent use of the local personalised care and support planning systems and documents including symptom management and advance care plans
- up-to-date knowledge of legal frameworks such as Mental Capacity Act, Lasting Powers of Attorney, Advance Decision to Refuse Treatment, safeguarding requirements, learning disabilities training (e.g. Oliver McGowan) and The Children’s Act
- Advanced communication skills and training for PCEoLC
- Clinical leadership skills and clinical supervision capability

Integration with wider health, education and social care system; services and agencies.

In the delivery of an integrated service, interdependencies exist between the specialist-level palliative care services and: primary and community providers – general practice, district nurses and out-of- hours services, community pharmacy

- other multidisciplinary specialist teams, including Allied Health Professionals
- rapid response team / urgent community response / virtual ward
- social care services – both in hours and out of hours
- providers of domiciliary care and residential and nursing homes
- other providers of PCEoLC services: statutory and voluntary
- providers of acute care
- urgent and emergency care services, including NHS 111 and ambulance services
- providers of services for individuals with long-term conditions
- local authority services, including education and all education settings.
- health visiting/school health nursing
- Community mental health and learning disability services.

The workforce delivering this core component should align to Neighbourhood footprints as appropriate.

Any specifics the service must meet for national requirements

NICE Guidelines:

- End of life care for adults: Service delivery (NICE NG142):
- End of Life care for adults (NICE QS13)
- End of life care for infants, children and young people (NICE QS160)

NHS England:

- Palliative and End of Life Care. Statutory Guidance for Integrated Care Boards
- Specialist palliative and end of life care services. Adult and Children and Young People service specification
- Universal Principles for Advance Care Planning

National Palliative and End of Life Care Partnership

- Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026

Local data reporting, National data reporting not required

All advice should be included in a patient record and form part of the record. A record of the contact (telephone/face to face/email) should be recorded in the case notes by those providing the service and by the professional contacting the service and coded as “Specialist Palliative Care advice”.

Community occupational therapy (CYP)

Children’s community occupational therapy services support children and young people with a range of physical, learning, sensory and psychosocial needs to grow, thrive and take part in the everyday activities and routines (occupations) that give purpose and meaning to their lives.

Description of the service

Occupational therapists work with babies, children, young people and the people who support them to identify the daily activities and routines they need and want to do, and the personal, environmental and task-specific factors that help or limit their ability to take part. They provide different levels of occupation-focused support (universal, targeted and individualised) to enable children and young people to realise their potential, participate and enjoy life.

Occupational therapists work collaboratively with children, young people and their families, and with partners in health, education, care and community services to provide integrated support that meets individual and population needs.

Children’s community occupational therapy services provide different levels of support, based on local population needs. This includes:

- **Universal support** – website resources, telephone/online advice lines, and prevention/early intervention support for families, schools and settings
- **Targeted support** – therapy groups, coaching, parent/carer/teacher workshops, therapy programmes developed by an OT but delivered by a teaching/therapy assistant, advice and support re. environmental or task modifications to improve school/setting accessibility
- **Individualised support** – input to, co-ordination and leadership of OT provision in Education, Health and Care Plans, participation in SEND mediation and dispute resolution activities, provision of assessment, diagnosis and direct therapy for children and young people requiring tailored support for their complex needs/circumstances or at times of transition (direct therapy is goal-orientated and strengths-based)

Providing health advice for Education, Health and Care (EHC) needs assessments and annual reviews. An Education, Health and Care (EHC) needs assessment evaluates a child or young person's education, health, and care needs and helps to determine whether an EHC plan is necessary to meet the child or young person's needs and what support and services are required.

Providing advice and signposting about the SEND local offer. All local authorities are required to publish a Local Offer, setting out up to date information about services for children and young people with SEND. Health services must make sure that information on the local offer is accurate, easy to access and up to date.

Working jointly with families and including the voice of the child or young person in the planning of care.

Supporting young people to transition into adult health services, including working with the young person to develop a transition plan (see 8.54 of the SEND code of practice) including further education/employment, managing their own conditions where appropriate and transitioning to adult services.

Areas of support might also include:

- Preparing young people for adulthood, including further education/employment and transition to adult services
- Self-management of life-long conditions such as cerebral palsy and developmental coordination disorder
- Transition from hospital to home (including after an illness, injury or from neonatal care)
- Palliative care and end of life care

Services are provided in a diverse range of community settings that may include a child or young person's home, early years settings, family hubs, child development centres, schools (special and mainstream), colleges, respite care and clinics.

Telephone and online support/consultations are offered where appropriate.

Where necessary, services will be required to engage in activity relating to resolution of complaints, mediation and SEND tribunal activity.

Services will need to engage in additional SEND training in line with the SEND Training Assurance Framework.

Who is the service for

Occupational therapy is provided for children and young people whose activity and participation are limited due to health, development and wellbeing, physical, learning, sensory, mental health, environmental and/or social needs.

This includes, but is not limited to children and young people whose participation and development is affected by:

- Neuro disability such as cerebral palsy, and types of neurodivergence including developmental coordination disorder and autism
- Illness or injury
- Developmental delay
- Preterm birth
- Special educational needs and disabilities (SEND) including children and young people with an Education, Health and Care Plan, and those receiving SEN support.
- Complex physical and learning disabilities
- Environmental barriers including inaccessible spaces, routines and expectations
- Social and emotional challenges

Children and Young People in education settings regardless of the type of setting, Local Authority or non-Local Authority funded.

Access and response times for first contact with service user

The Medium Term Planning Framework asks systems to actively manage long waits for community health services, reducing the proportion of waits over 18 weeks and developing a plan to eliminate all 52-week waits.

Capabilities required at a population level

Service planning and resourcing of children's community occupational therapy services should be evidence-informed and based on local population needs and workforce data.

For effective service delivery, children's occupational therapy services should include registered therapists trained in paediatrics, working at all levels of practice (including enhanced and advanced level practitioners), therapy support workers and administrative support.

Workforce planning tools should be used to ensure occupational therapists are available and deployed into roles that fully utilise their core professional skills

Other population-level capabilities required of children's community occupational therapy services include:

- Knowledge of child development and factors that can affect children and young people's participation in self-care, learning and leisure activities

- Knowledge of and capabilities to address/support social determinants of health including housing, poverty,
- education, nutrition, environmental factors and adverse childhood experiences
- Expertise in the assessment and management of physical, learning and mental health needs that affect children’s participation, development and wellbeing
- Ability to effectively triage referrals to ensure appropriate, timely support
- Ability to provide support in children’s natural contexts e.g. for travel, access to age-appropriate equipment
- Knowledge of and compliance with legal frameworks such as safeguarding protections and The Children and Families Act 2014.
- Awareness of local community services available to support children, young people and families
- Knowledge of equipment and suppliers and procedures for procurement and monitoring
- Integrated data systems to enable coordinated, effective and timely care planning across systems
- Access to clinical supervision and support for professional development
- Access to technology equipment and digital maturity to ensure appropriate and effective use of telehealth
- Ability to work autonomously (but understands when and how to see further specialist support and advice)
- Clinical leadership and representation at an organisational and strategic planning level

Integration with wider health, education and social care system; services and agencies.

Children’s community occupational therapy is embedded within the wider system providing multi-agency support and care planning for individuals, families and populations. Services should be co-produced with children, young people and families. Partners include, but are not limited to:

- **Health**: other allied health professionals (e.g. speech and language therapy, physiotherapy, dietetics), community paediatrics, child and adolescent mental health services, children’s community nursing, health visitors, tertiary centres and general practitioners.
- **Education**: local authority SEND teams, EHCP coordinators, Designated Clinical Officers, educational psychologists, schools, nurseries and school mental health support teams
- **Social care**: local authority occupational therapy services, social workers, safeguarding teams, family support and disability services, and housing teams.

- **Third sector organisations**: Parent/carer networks, local and national support organisations
- **Secondary and tertiary services**: including neonatal care, acute and rehabilitation services

Children's occupational therapy services contribute to multi-agency planning, assessment and support activities, including Education Health and Care Plans, SEND mediation and resolution activities, Continuing Health Care plans, and care packages for looked-after children.

Strategic co-production with parent carers and young people: Services will need to work with voice organisations and groups such as such as parent carer forums and children and young people's participation groups.

The workforce delivering this core component should align to Neighbourhood footprints as appropriate.

Any specifics the service must meet for national requirements

Registered occupational therapists are regulated by the Health and Care Professions Council (HCPC) and must adhere to HCPC standards.

Children's occupational therapy services must:

- Participate in community data collection and reporting as required for NHS service monitoring
- Comply with safeguarding standards and legal frameworks including the Children and Families Act 2014 and SEND Code of Practice.
- Respond to Education, Health and Care Needs assessment requests and provide assessment reports where required within the statutory timeframe (6 weeks)

National data submission guidance

Record service or team referred to as '26 – Occupational Therapy Service' (in table CYP102 Service or Team Type Referred To in CSDS, and table 6.b REFERRAL_SERVICE in FDF).

Ensure date of birth is recorded (in the MPI table CYP001 in CSDS, and table 5a.CARE_MPI in FDF).

In the CHS Sitrep record under '(CYP) Therapy interventions: Occupational therapy'.

Community physiotherapy (CYP)

Children's community physiotherapy services support the assessment, treatment, and management of children and young people with physical and developmental conditions affecting movement, posture, or functional ability.

Description of the service

Children's community physiotherapy provision will vary dependent on local arrangements, but may deliver:

- **Assessment and early intervention** for children with congenital, developmental, neurological, and musculoskeletal conditions.
- **Physiotherapy** input to special Education Health and Care Plans
- **Rehabilitation and habilitation** including after injury or orthopaedic surgery (e.g. fractures).
- **Support and advice** to families, schools, and other services to promote inclusion and functional ability in home, educational, and community settings.

Common conditions may include cerebral palsy, developmental coordination disorder (DCD), musculoskeletal disorders and injuries, postural problems, neuromuscular disorders, and joint hypermobility syndrome.

CYP community physiotherapy services may also provide support in preparing young people for adulthood including further education/employment, managing their own conditions where appropriate and transitioning to adult services.

Providing health advice for Education, Health and Care (EHC) needs assessments and annual reviews. An Education, Health and Care (EHC) needs assessment evaluates a child or young person's education, health, and care needs and helps to determine whether an EHC plan is necessary to meet the child or young person's needs and what support and services are required.

Providing advice and signposting about the SEND local offer. All local authorities are required to publish a Local Offer, setting out up to date information about services for children and young people with SEND. Health services must make sure that information on the local offer is accurate, easy to access and up to date.

Services are provided in a diverse range of community settings that may include a child or young person's home, early years settings, family hubs, child development centres, schools (special and mainstream), colleges, respite care and clinics. Telephone and online support/consultations are offered where appropriate

Working jointly with families and including the voice of the child or young person in the planning of care.

Supporting young people to transition into adult health services, including working with the young person to develop a transition plan (see 8.54 of the SEND code of practice) including further education/employment, managing their own conditions where appropriate and transitioning to adult services.

Where necessary, services will be required to engage in activity relating to resolution of complaints, mediation and SEND tribunal activity.

Services will need to engage in additional SEND training in line with the SEND Training Assurance Framework.

Models of delivery vary locally, and these functions can be integrated within one community MSK provider. Services are delivered in community settings, including health centres and clinics, with some digital options available.

Who is the service for

Children and young people with developmental, neurological, or musculoskeletal conditions that impair physical function, motor development, or participation in daily activities.

This includes (but is not limited to) children:

- With long-term conditions like cerebral palsy or neuromuscular disorders.
- Recovering from surgery or injury.
- At risk of developmental delay (e.g., premature birth, genetic syndromes)
- Profound and complex learning disabilities
- Requiring support for postural management or mobility.
- With pain and functional limitation associated with MSK conditions that affect joints, bones and muscles and sometimes associated tissues such as nerves including congenital conditions e.g. OBPP, Torticollis, Talipes
- Rheumatological conditions e.g. JIA

Children and Young People in education settings regardless of the type of setting, Local Authority or non-Local Authority funded.

Access and response times for first contact with service user

National and local standards generally aim to see children within 6-18 weeks from referral, but there is no universal NHS standardised target. Priority is often given to:

- CYP with rapidly deteriorating function or recovery needs post-surgery, or post injury.
- CYP who require input to facilitate discharge from hospital
- Infants with developmental delay if neurological changes are observed and/or they are at risk of harm from postural issues (e.g., OBBP, torticollis).

The Medium Term Planning Framework asks systems to actively manage long waits for community health services, reducing the proportion of waits over 18 weeks and developing a plan to eliminate all 52-week waits.

Capabilities required at a population level

A multidisciplinary workforce including physiotherapists trained in paediatrics, therapy support workers, and administrative support is required for effective delivery. Services require dedicated space, age-appropriate equipment, and access to diagnostics where necessary.

Strategic workforce tools and local needs assessments should be considered to inform service planning and resourcing. ￼

- Delivered in clinical settings, homes and education settings, community settings eg family hubs.
- Integrated data systems to support risk stratification and shared care planning.
- Workforce planning tools to deploy teams according to local population need.
- Capabilities in addressing social determinants of health, including housing, transport, loneliness, and nutrition.
- Digital maturity to enable digital assessment and intervention for services remote monitoring, and telehealth as necessary.
- Knowledge and expertise in relevant health conditions and management
- Knowledge of the available local services for community health
- Knowledge of medicines for relevant health conditions and how (prescriber and prescription) they can be obtained
- Knowledge of equipment for relevant health conditions (in multiple settings) and suppliers
- Up to date knowledge of legal frameworks such as safeguarding requirements and the Children Act 1989, the Children Act 2004 and the Children and Families Act 2014 and SEND Code of Practice.
- Specialist knowledge to be able to effectively triage requests for support or assessment of need
- Adequate capacity within the community to respond to requests for face-to-face support

- Communication skills and training for people with complex long-term conditions,
- Clinical leadership skills and clinical supervision capability
- Ability to work autonomously (but has awareness of when to seek further specialist support and advice)
- Advanced practitioners, including physiotherapists to lead MDTs and deliver complex decision-making, prescribing, and investigations.

Integration with wider health, education and social care system; services and agencies.

Children’s community physiotherapy services are embedded in the wider system and typically coordinate with:

- **Health**: other allied health professionals (e.g. speech and language therapy, occupational therapists, dietetics), community paediatrics, child and adolescent mental health services, children’s community nursing, health visitors, tertiary centres and general practitioners.
- **Education**: Local authority SEND teams, EHCP coordinators, Designated Clinical Officers, educational psychologists, schools, nurseries and school mental health support teams
- Designated Clinical Officers (DCOs): Close working relationships with DCOs around compliance to SEND code of practice 0-25 years, SEND quality assurance and improvement and developing SEND specific knowledge and skills within the service
- Requirement to provide EHC needs assessment and advice
- Work jointly with early years practitioners, teachers, teaching assistants, senior leadership teams in school and school-based therapy teams.
- **Social care**: local authority occupational therapy services, social workers, safeguarding teams, family support and disability services, and housing teams, and housing teams.
- **Third sector organisations**: Parent/carer networks, local and national support organisations
- **Secondary and tertiary services**: coordinating discharge plans, specialist guidance, and supporting shared care pathways
- General practice as a potential referral source

Services often contribute to multi-agency planning meetings such as those relating to EHCP needs assessments, annual reviews and safeguarding, health promotion in educational and physical health settings and joint delivery of early intervention or complex care pathways.

Strategic co-production with parent carers and young people: Services will need to work with voice organisations and groups such as such as parent carer forums and children and young people’s participation groups.

The workforce delivering this core component should align to Neighbourhood footprints as appropriate.

Any specifics the service must meet for national requirements

Children's physiotherapy services must:

- Participate in community data collection and reporting, where applicable, for NHS service monitoring.
- Comply with safeguarding standards and child-friendly service design
- the Children and Families Act 2014 and SEND Code of Practice:
  must provide advice for Education, Health, and Care Needs Assessment (EHCNA) within a statutory timeframe of 6 weeks.
- NHS Safeguarding: safeguarding & trauma informed practice via our free NHS Safeguarding Agile Guide (L1) and our NHS Safeguarding Future NHS learning platform (L2+) if you are more professionally curious; our Safeguarding Webinars & Learning Together Weeks - NHS Safeguarding Workspace - FutureNHS Collaboration Platform (L3+) and our L4/5 ICB Level 4 Leadership recordings - NHS Safeguarding Workspace - FutureNHS Collaboration Platform
- NHS England » Commissioning framework for children and young people with cerebral palsy
- Children and Families Act 2014, section 23 notifying the local authority of children under the compulsory school age who in the opinion of the ICB or Trust has SEND and may require SEND provision.
- SEND Code of Practice, regulation 6(1)(d) when a local authority (LA) carries out an EHC needs assessment, they must seek medical advice and information from a health professional.

National data submission guidance

Record service or team referred to as '26 - Physiotherapy Service' (in table CYP102 Service or Team Type Referred To in CSDS, and table 6.b REFERRAL_SERVICE in FDF).

Ensure date of birth is recorded (in the MPI table CYP001 in CSDS, and table 5a.CARE_MPI in FDF).

In the CHS Sitrep record under '(CYP) Therapy interventions: Physiotherapy'.

Community speech and language therapy (CYP)

CYP speech and language therapy provides assessment, intervention and support for children who have difficulties with communication and/or with eating, drinking and swallowing.

Description of the service

Speech and language therapists provide treatment, support advice, signposting and care for CYP who have speech, language and communication needs and/or children with eating, drinking and swallowing needs.

Children's speech and language therapy services provide different levels of support, based on local population needs. This includes:

- **Universal support** – Interventions which support a wider population of children and young people and may include website resources, telephone/online advice lines, and prevention/early intervention support for families, schools and settings
- **Targeted support** – supporting the delivery of group-based interventions in education settings, coaching, parent/carer/teacher workshops, use of strategies and resources modelled by a Speech and Language Therapist and delivered by a teaching/therapy assistant, advice and support re. environmental or task modifications to improve school/setting accessibility
- **Specialist support** – provision of direct intervention for children and young people with an identified clinical need requiring tailored and individualised support. Input to, co-ordination and oversite of speech and language therapy provision in Education, Health and Care Plans, support for their complex needs/circumstances or at times of transition. Direct therapy is goal-orientated, strengths-based and delivered with the involvement of education staff, parents/carers who can embed into the child's wider experience.

Speech and language therapy services vary dependent on commissioning arrangement. Services will typically support children and young people for the following types of need:

- Speech
- Language
- Stammering
- Complex needs
- Voice
- Oropharyngeal Dysphagia / eating drinking and swallowing
- Augmentative and Alternative Communication (AAC)
- Input into EHCNAs.

Provide expert advice about children and young people with complex speech, language and communication needs and the impact their needs will have on everyday life and learning experiences.

Providing health advice for Education, Health and Care (EHC) needs assessments and annual reviews. An Education, Health and Care (EHC) needs assessment evaluates a child or young person's education, health, and care needs and helps to determine whether an EHC plan is necessary to meet the child or young person's needs and what support and services are required.

Providing advice and signposting about the SEND local offer. All local authorities are required to publish a Local Offer, setting out up to date information about services for children and young people with SEND. Health services must make sure that information on the local offer is accurate, easy to access and up to date.

Services are provided in a diverse range of community settings that may include a child or young person’s home, early years settings, family hubs, child development centres, schools (special and mainstream), colleges, respite care and clinics. Telephone and online support/consultations are offered where appropriate.

Working jointly with families and including the voice of the child or young person in the planning of care.

Supporting young people to transition into adult health services, including working with the young person to develop a transition plan (see 8.54 of the SEND code of practice) including further education/employment, managing their own conditions where appropriate and transitioning to adult services. Services will need to engage in additional SEND training in line with the SEND Training Assurance Framework.

Who is the service for

Children’s speech and language therapy is for children who have speech, language and communication needs and children with eating, drinking and swallowing needs.

Inclusion and exclusion criteria may vary between service depending on commissioning arrangements, but might typically include:

- Speech disorders: issues with pronunciation, articulation, or motor speech (e.g., apraxia, cleft palate and Velopharyngeal Dysfunction).
- Language difficulties: including Developmental Language Disorder / Language Disorder
- Social communication differences

- Stammering (stuttering): disruptions in speech flow.
- Voice disorders.
- Feeding and swallowing difficulties
- Developmental delays
- Hearing impairments: Impacting speech and language skills.

Children and Young People in education settings regardless of the type of setting, Local Authority or non-Local Authority funded.

Exclusion Criteria:

Non-communicative disorders: Conditions unrelated to speech, language, or swallowing (e.g., severe physical disabilities not affecting communication or swallowing).

Access and response times for first contact with service user

The Medium Term Planning Framework asks systems to actively manage long waits for community health services, reducing the proportion of waits over 18 weeks and developing a plan to eliminate all 52-week waits.

Capabilities required at a population level

A multidisciplinary workforce including Speech and language therapists trained in paediatrics, therapy support workers, and administrative support is required for effective delivery.

- Delivered in clinical settings, homes and education settings, community settings eg family hubs.
- Population health intelligence to identify high-risk individuals and areas of high demand.
- Integrated data systems to support risk stratification and shared care planning.
- Workforce planning tools to deploy teams according to local population need.
- Capabilities in addressing social determinants of health, including housing, transport, loneliness, and nutrition.
- Digital maturity to enable remote monitoring, and telehealth as necessary.
- Knowledge and expertise in relevant health conditions and management
- Knowledge of the available local services for community health
- Knowledge of medicines for relevant health conditions and how (prescriber and prescription) they can be obtained
- Knowledge of equipment for relevant health conditions (in multiple settings) and suppliers

- Up to date knowledge of legal frameworks such as safeguarding requirements and the Children Act 1989, the Children Act 2004 and the Children and Families Act 2014 and the SEND code of practice: 0-25 years
- Specialist knowledge to be able to effectively triage requests for support or assessment of need
- Adequate capacity within the community to respond to requests for face-to-face support. Including Bilingualism, RCSLT state at least double the time is required for bilingual clients and their families to achieve the same positive outcomes as monolingual clients, and therefore deliver an equitable service.
- Communication skills and training for people with complex long-term conditions,
- Clinical leadership skills and clinical supervision capability
- Ability to work autonomously (but has awareness of when to seek further specialist support and advice)

Integration with wider health, education and social care system; services and agencies.

Health: pathways feeding in from audiology, health visiting teams and community paediatrics and sharing outcomes with referring general practice. MDT approaches and integrated therapy teams e.g. working collaboratively with OTs and Physiotherapy, nutrition and dietetics, non-registered AHP / therapy staff, hospital specialist teams such as video fluoroscopy, voice, ENT, consultants, neurodevelopmental and behaviour pathway teams

Designated Clinical Officers (DCOs): Close working relationships with DCOs around compliance to SEND code of practice 0-25 years, SEND quality assurance and improvement and developing SEND specific knowledge and skills within the service.

Education: work jointly with early years practitioners, teachers, teaching assistants, school based therapy teams and senior leadership teams to develop ‘whole school’ or ‘whole setting’ approaches to supporting SLCN, they support schools and settings to deliver targeted interventions, provide staff training and advice, and deliver interventions for children, including those on SEN support and those with an EHCP.

Liaising with education professionals such as Specialist teachers, Education Psychologists, SEN service.

Social Care: working alongside:

- Social Workers working with children in care, with disabilities, or those at risk of neglect.
- Child Protection Services, addressing communication issues linked to abuse or neglect.

- Family Support Services supporting families to help children’s communication at home.

Third sector organisations: Parent/carer networks, local and national support organisations

Secondary and tertiary services: coordinating discharge plans, specialist guidance, and supporting shared care pathways

Strategic co-production with parent carers and young people: Services will need to work with voice organisations and groups such as such as parent carer forums and children and young people’s participation groups.

The workforce delivering this core component should align to Neighbourhood footprints as appropriate.

Any specifics the service must meet for national requirements

Section 23 Children and Families Act 2014, notifying the local authority of children under the compulsory school age who in the opinion of the ICB or Trust has SEND and may require SEND provision.

Under regulation 6(1)(d) of the SEND Regulations 2014, when a local authority (LA) carries out an EHC needs assessment, they must seek medical advice and information from a health professional.

Relevant NICE guidelines, including:

- Disabled children and young people up to 25 with severe complex needs (NG213): integrated service delivery and organisation across health, social care and education
- Transition from children’s to adults’ services for young people using health or social care services (NG43)
- Babies, children and young people's experience of healthcare (NG204)

Children and Families Act and SEND Code of Practice, must provide advice for Education, Health, and Care Needs Assessment (EHCNA) within a statutory timeframe of 6 weeks

The Health and Care Professions Council (HCPC) regulates speech and language therapists (SLTs). Registration is a legal requirement for all practising SLTs, who must adhere to the following HCPC standards:

- Standards of conduct, performance and ethics
- Standards of proficiency for speech and language therapists

- Standards of continuing professional development
- Standards of education and training

National data submission guidance

Record service or team referred to as ‘33 - Speech and Language Therapy Service’ (in table CYP102 Service or Team Type Referred To in CSDS, and table 6.b REFERRAL_SERVICE in FDF).

Ensure date of birth is recorded (in the MPI table CYP001 in CSDS, and table 5a.CARE_MPI in FDF)

In the CHS Sitrep, record under ‘(CYP) Therapy interventions: Speech and language’.

Community paediatrics

Community paediatrics services provide specialist care and support for children and young people with developmental, behavioural, and physical health needs. Services are delivered by multidisciplinary teams of paediatricians, nurses, allied health professionals (AHPs), psychologists and support staff working in collaboration with families, schools, educational environments, and other healthcare professionals to deliver holistic care. Services will work with and listen to the views of the child or young person to deliver person-centred care.

Description of the service

Community paediatrics services vary vastly dependent on commissioning arrangements, typical activities include, but are not limited to:

1) Assessment, diagnosis and management of babies and CYP with developmental, neurodevelopmental conditions (including assessments for ADHD and autism which are often co-morbid) and developmental and neurodevelopmental disorders and disabilities. Commissioning models for neurodevelopmental assessment vary, with provision existing in CYP mental health services, community paediatric services and integrated pathways (reporting of assessment must reflect commissioning route)
2) Education, Health and Care Needs Assessment
    - Providing health advice for Education, Health and Care needs assessments and annual reviews
    - Providing health advice within 6 weeks of request
    - Providing updated information for annual reviews
3) Safeguarding, including
    - Utilising the Child Protection Information System
    - Child protection medical assessment for physical / emotional abuse and neglect.
    - child sexual abuse / exploitation assessment
    - active participation in child protection conferences, multi-agency safeguarding hubs and multi-agency child protection teams
    - Section 17 (child in need) and Section 47 (child protection plan, including harms-outside-the-home) referrals.
4) Children in Care: children in care Initial health assessments (IHA), Adoption Medicals and Review Health Assessment (RHA)
5) Physical complex health need condition management and support.
   Supporting palliative and end of life care for CYP; i.e. Advanced Care Planning, symptom management.

Community paediatrics services offer **management of complex health needs, ongoing support, regular reviews**, supported transition and referrals to relevant services. Care is delivered in **community clinics, hospital clinics, educational environments and sometimes at home**, with remote consultations available when appropriate.

The following **Core component descriptions** include further detail on:

1) Neurodevelopmental assessment
2) Neurodisability assessment
3) Education, Health and Care needs assessment
4) Safeguarding
5) Children in care

Who is the service for

Community Paediatrics provision varies vastly dependent on commissioning arrangements. Community paediatrics focuses on children with long-term and complex conditions rather than acute care.

Children with primary mental health concerns are generally not managed by community paediatrics unless there is an underlying developmental condition or they are referred to an integrated service. For example, children with depression, anxiety, or eating disorders are usually referred to CYP mental health services. .

Children with mild or isolated behavioural concerns that are not linked to a neurodevelopmental condition are generally not eligible. For example, typical toddler tantrums or school-related behavioural issues without medical causes are usually managed by parenting support programmes or educational psychologists.

Cases where the primary issue is related to education (e.g., learning difficulties without a medical condition) are referred to schools or educational services rather than community paediatrics.

Access and response times for first contact with service user

Variable dependent on pathways, examples include:

- Initial Health Assessment must be conducted within 20 working days of a child coming into care
- Safeguarding assessments: vary dependent on urgency / whether planned, can take place on the same day in urgent cases.
- NICE guideline for autism assessment states no one should wait longer than 13 weeks, average waiting times far exceed this at the time of writing / publication.
- Further to the NICE Prioritisation Board decision on reviewing the autism guidelines, decisions about aspects being prioritised or scope have not yet been decided. Therefore, it is not yet known whether revisions will be made to the waiting time.
- Providing health advice for EHCPs within 6 weeks of request.

The Medium Term Planning Framework asks systems to actively manage long waits for community health services, reducing the proportion of waits over 18 weeks and developing a plan to eliminate all 52-week waits.

Capabilities required at a population level

The Royal College of Paediatrics and Child Health previously provided a workforce calculator, designed for community paediatricians and service planners to calculate the community paediatric consultant and SAS doctor workforce for their service to meet demand and national guidelines. Whilst this has been discontinued, metrics used for the calculator can be found on the RCPCH guide: *Covering all bases, Community Child Health: A paediatric workforce guide.*

The medical capacity needed also depends on other factors including supporting admin, Multi-Disciplinary Team (MDT), and multiagency capacity within the Community Paediatric team. It also depends on digital maturity of the organisation. Good Electronic Patient Records (EPR), Ambient voice technology and care coordination may all reduce the medical capacity needed.

Up to date knowledge of legal frameworks such as safeguarding requirements and the Children Act 1989, the Children Act 2004 and the Children and Families Act 2014 and the SEND code of practice: 0-25 years.

Integration with wider health, education and social care system; services and agencies.

- **Health** services: e.g. general practice (including through provision of outcome reports and receipt of referrals), health visitors, school nurses, AHPs (including physiotherapists, occupational therapists and speech and language therapists), dietetics and Children and Young People’s mental health services, and Neighbourhood MDTs for CYP to address physical and mental health needs, working flexibly to CYP needs*. Neighbourhood MDTs for CYP Framework.* NB this list is not exhaustive

- Designated Clinical Officers (DCOs): Close working relationships with DCOs around compliance to SEND code of practice 0-25 years, SEND quality assurance and improvement and developing SEND specific knowledge and skills within the service.
- **Local Authority, education** and **social care**: working with local authorities to support safeguarding, looked after children's assessments, health needs of CYP with SEND, and the health needs of looked-after children ensuring coordinated care. Close working relationships with educational environments, nurseries, and educational psychologists to support children’s learning and development.
- **VCSE services**: signposting families to appropriate organisations and charities, offering information, practical and emotional support, and advocacy services. Working with parents, carers and children and young people to improve services (strategic co-production) and working with and listening to individual children and young people and their families regarding their care.
- Where CYP are on multiple waiting lists integrated approaches across pathways should be considered.

The workforce delivering this core component should align to Neighbourhood footprints as appropriate.

Any specifics the service must meet for national requirements

Statutory duties:

Children and Families Act and SEND Code of Practice:

- Must provide advice for Education, Health, and Care Plan Needs Assessment within a statutory timeframe of 6 weeks.
- Section 23 (C&F Act, 2014) sites that if a child may have SEND, Health Service’s must notify the local authority when they come in contact with a child under statutory school age. A process must be in place to ensure this occurs.

NICE Guidelines:

- **Autism Diagnosis (NICE CG128):** Requires a **multidisciplinary ‘Autism team’** including a paediatrician and/or child and adolescent psychiatrist, speech and language therapist and psychologist with training and experience in working with autistic CYP **as core members**. The ‘Autism team’ should also include or have regular access to, if not already in the team, a paediatrician, paediatric neurologist and occupational therapist.

- However, for clarity; ***each child does not have to be seen by each of these professionals.***
- Further to the NICE Prioritisation Board decision on reviewing the autism guidelines, decisions about aspects being prioritised or scope have not yet been decided.
- **ADHD Diagnosis (NICE NG87):** Diagnosis must be made by a **specialist ADHD service**, including **paediatricians or child psychiatrists**.
- NHSE:A national framework to deliver improved outcomes in all-age autism assessment pathways: guidance for integrated care boards**:** The framework and operational guidance outline core principles to apply in the commissioning and delivery of autism assessment pathways, including assessments taking place in a range of settings and under unusual conditions.
- **Child Maltreatment (NICE CG89):** Guidance on identifying and responding to child abuse, influencing safeguarding medical assessments.
- Disabled children and young people up to 25 with severe complex needs (NG213): integrated service delivery and organisation across health, social care and education
- Transition from children's to adults' services for young people using health or social care services (NG43)
- Babies, children and young people's experience of healthcare (NG204)

Royal College of Paediatrics and Child Health (RCPCH) Standards:

- Safeguarding: Services must meet RCPCH safeguarding guidelines, including timeliness of child protection medicals.

Guidance on neighbourhood multidisciplinary teams for children and young people NHS England » Guidance on neighbourhood multidisciplinary teams for children and young people

National data submission guidance

Specific data submission guidance is provided below for each subcomponent.

Community paediatrics: 1) Neurodevelopmental assessment; 2) Neurodisability assessment.

Neurodevelopmental and Neurodisability assessments are a comprehensive evaluation of a child's abilities, needs, and difficulties. The assessment focuses on the entire child and their strengths and needs to provide a developmental profile.

Description of the service

Community paediatrics services vary vastly dependent on commissioning arrangements, though will typically include assessment for neurodevelopmental conditions and Neurodisability:

1) A neurodevelopmental assessment is a comprehensive evaluation of a child's abilities, needs, and difficulties. It's an assessment that helps a team understand a child's health and development. It can also help adults identify what they can do to support the child now and in the future. The assessment focuses on the entire child and their strengths and needs to provide a developmental profile and can contribute towards an autism and/or ADHD diagnosis.
   Assessment methodology varies depending on the child's age. Assessment reports should distinguish between assessments for under-5s and those for ages 5–18.

2) Neurodisability is an umbrella term for conditions associated with impairment of functioning relating to any condition that affects the brain and / or nervous system. This includes cerebral Palsy, neuromuscular conditions, hearing impairment, visual impairment and genetic syndromes.

Who is the service for

Children with symptoms meeting the appropriate threshold for referral for:

1) Neurodevelopmental assessment – including but not limited to ADHD, ASD and

2) Neurodisability – including but not limited to cerebral Palsy, neuromuscular conditions, deafness, blindness, and genetic syndromes.

Community Paediatrics provision varies vastly dependent on commissioning arrangements. Community paediatrics focuses on long-term and complex cases rather than acute care. Children with mild or isolated behavioural concerns that are not linked to a neurodevelopmental condition are generally not eligible. For example, typical toddler behaviour without medical causes or school-related behavioural issues without medical causes are usually managed by other commissioned support such as parenting support programmes.

Access and response times for first contact with service user

NICE guideline for autism assessment states no one should wait longer than 13 weeks, average waiting times far exceed this at the time of writing / publication.

Further to the NICE Prioritisation Board decision on reviewing the autism guidelines, decisions about aspects being prioritised or scope have not yet been decided. Therefore, it is not yet known whether revisions will be made to the waiting time.

The Medium Term Planning Framework asks systems to actively manage long waits for community health services, reducing the proportion of waits over 18 weeks and developing a plan to eliminate all 52-week waits.

Capabilities required at a population level

As neurodevelopmental assessment sits as a pathway in a community paediatrics service, figures shared are for broader community paediatrics service provision above.

Integration with wider health, education and social care system; services and agencies.

- **Health services**: general practice (including through provision of outcome reports and receipt of referrals), health visitors, school nurses, AHPs (including physiotherapists, occupational therapists and speech and language therapists), and Children and Young People’s mental health services and Neighbourhood MDTs for CYP to address physical and mental health needs working flexibly to CYP need. NB this list is not exhaustive. Designated Clinical Officers (DCOs): Close working relationships with DCOs around compliance to SEND code of practice 0-25 years, SEND quality assurance and improvement and developing SEND specific knowledge and skills within the service.
- **Local Authority, education** and **social care**: working with local authorities to support safeguarding, looked after children's assessments, health needs of CYP with SEND, and the health needs of looked-after children ensuring coordinated care. Close working relationships with educational environments, nurseries, and educational psychologists to support children’s learning and development. This includes engaging in strategic SEND partnership plans and providing health input for Education,
- Health, and Care Plans (EHCPs) and offering guidance to education settings about complex health needs.

- **VCSE services**: signposting families to appropriate organisations and charities, offering information, practical and emotional support, and advocacy services.

The workforce delivering this core component should align to Neighbourhood footprints as appropriate.

Any specifics the service must meet for national requirements

- **Autism Diagnosis (NICE CG128)**: Requires a **multidisciplinary 'Autism team'** including a paediatrician and/or child and adolescent psychiatrist, speech and language therapist and psychologist with training and experience in working with autistic CYP **as core members**. The 'Autism team' should also include or have regular access to, if not already in the team, a paediatrician, paediatric neurologist and occupational therapist.
- However, for clarity; ***each child does not have to be seen by each of these professionals.***
- Further to the NICE Prioritisation Board decision on reviewing the autism guidelines, decisions about aspects being prioritised or scope have not yet been decided.
- **ADHD Diagnosis (NICE NG87)**: Diagnosis must be made by a specialist ADHD service, including paediatricians or child psychiatrists.
- **NHSE: A national framework to deliver improved outcomes in all-age autism assessment pathways: guidance for integrated care boards.** The framework and operational guidance outline core principles to apply in the commissioning and delivery of autism assessment pathways.

National data submission guidance

Record service or team referred to as '06 - Community Paediatrics' (in table CYP102 Service or Team Type Referred To in CSDS and table 6.b REFERRAL_SERVICE in FDF).

Ensure date of birth is recorded (in the MPI table CYP001 in CSDS, and table 5a. CARE_MPI in FDF).

To record referrals at each step in the referral pathway for suspected autism and ADHD, please follow this technical guidance:

Recording autism and ADHD assessments in Community Services Data Set (CSDS) - NHS England Digital

At present, there is not prescriptive national guidance on how to record other types of assessments within Community Paediatrics, however an assessment should be recorded in the care activity table, linked to the care contact in which it occurred (table CYP202 in CSDS, 7b. CARE_ACTIVITY in FDF), using data item Community Care Activity Type, selecting 02

Assessment. Detailed guidance will be developed over time. However, organisations should be recording this activity locally.

In the CHS Sitrep, record activity under ‘(CYP) Community paediatric service.’

Community paediatrics: 3) Special educational needs and disability (SEND)

Education, Health and Care Needs Assessment (EHCNA)

See Children & Families Act (2014) Special Educational Needs and Disability.

Special educational needs and disability code of practice: 0 to 25 years. Statutory guidance for organisations which work with and support children and young people who have special educational needs or disabilities January 2015.

Description of the service

Community paediatrics services vary vastly dependent on commissioning arrangements, though it should include:

Notifying the local authority of children under the compulsory school age who in the opinion of the ICB or Trust has SEND and may require SEND provision (Section 23 Children and Families Act 2014)

Provide expert medical advice (medical assessment and report) where required, about children and young people with complex health needs and the impact their health needs will have on safe participation in an education setting.

Providing health advice for Education, Health and Care needs assessments and annual reviews. An Education, Health and Care needs assessment evaluates a child or young person's education, health, and care needs. An EHC needs assessment helps to determine whether an EHC plan is necessary to meet the child or young person's needs and what support and services are required.

Participation in SEND mediation, dispute resolution and tribunals. Mediation is a way to resolve disputes between the local authority and a parent/carer or young person that may require input from a healthcare professional to resolve. Health professionals may be required to provide information, advice and evidence more formally should a family make an appeal to the Special Educational Needs Tribunal.

Supporting young people to transition into adult health services, including working with the young person to develop a transition plan (see 8.54 of the SEND code of practice)

Providing advice and signposting about the SEND local offer. All local authorities are required to publish a Local Offer, setting out up to date information about services for children and young people with SEND. Health services must make sure that information on the local offer is accurate, easy to access and up to date.

Working jointly with families and including the voice of the child or young person in the planning of care.

Engage in SEND quality assurance, improvement and development planning.

Provide insights and information to the strategic SEND partnership board

Services will need to engage in additional SEND training in line with the SEND Training Assurance Framework

Who is the service for

Community Paediatrics provision varies vastly dependent on commissioning arrangements. Community paediatrics focuses on long-term and complex cases rather than acute care.

Children and young people with long term and complex health need that impact on their safe participation in education. These children may be supported in education through an SEN support plan or an EHC plan.

Cases where the primary issue is related to **education** (e.g., learning difficulties without a medical condition) are referred to **schools** or **educational services** rather than community paediatrics.

Access and response times for first contact with service user

SEND Regulations 2014, Regulation 8(1): Health professionals must provide their advice within **six weeks** of the request, unless exceptional circumstances apply.

The Medium Term Planning Framework asks systems to actively manage long waits for community health services, reducing the proportion of waits over 18 weeks and developing a plan to eliminate all 52-week waits.

Capabilities required at a population level

As EHCNA sit as a pathway in a community paediatrics service, figures shared are for broader community paediatrics service provision above.

Up to date knowledge of legal frameworks such as safeguarding requirements and the Children Act 1989, the Children Act 2004 and the Children and Families Act 2014 and the SEND code of practice: 0-25 years.

Integration with wider health, education and social care system; services and agencies.

- **Health services**: working with general practice (including through provision of outcome reports and receipt of referrals), health visitors, school nurses, AHPs (including physiotherapists, occupational therapists and speech and language therapists), and Children and Young People's mental health services and Neighbourhood MDTs for CYP to address physical and mental health needs. NB this list is not exhaustive.
- Designated Clinical Officers (DCOs): Close working relationships with DCOs around compliance to SEND code of practice 0-25 years, SEND quality assurance and improvement and developing SEND specific knowledge and skills within the service.
- **Local Authority, education** and **social care**: working with local authorities to support safeguarding, looked after children's assessments, health needs of CYP with SEND, and the health needs of looked-after children ensuring coordinated care. Close working relationships with educational environments, nurseries, and educational psychologists to support children's learning and development.
- **VCSE services**: signposting families to charities, support groups, and advocacy services that offer practical and emotional support. ￼
- **Strategic co-production with parent carers and young people**: Services will need to work with voice organisations and groups such as parent carer forums and children and young people's participation groups.

The workforce delivering this core component should align to Neighbourhood footprints as appropriate.

Any specifics the service must meet for national requirements

Section 23 Children and Families Act 2014, notifying the local authority of children under the compulsory school age who in the opinion of the ICB or Trust has SEND and may require SEND provision.

Under regulation 6 of the Special Educational Needs and Disability Regulations 2014, when a local authority (LA) carries out an EHCP they must seek medical advice and information from a health professional.

SEND Regulations 2014: regulation 6(1)(d) when a local authority (LA) carries out an EHC needs assessment; they must seek medical advice and information from a health professional. **Children and Families Act and SEND Code of Practice:**

Must provide advice for Education, Health, and Care Plan Needs Assessment (EHCPNA) within a statutory timeframe of 6 weeks.

Equality Act 2010 imposes a duty to make reasonable adjustments; public sector organisations must make changes in their approach or provision to ensure that services are accessible to disabled people as well as everybody else.

https://www.nice.org.uk/guidance/ng43

National data submission guidance

Record service or team referred to as '06 - Community Paediatrics' (in table CYP102 Service or Team Type Referred To in CSDS, and table 6.b REFERRAL_SERVICE in FDF).

Ensure date of birth is recorded (in the MPI table CYP001 in CSDS, and table 5a. CARE_MPI in FDF).

At present, there is not prescriptive national guidance on how to record EHCNAs, however an assessment should be recorded in the care activity table, linked to the care contact in which it occurred (table CYP202 in CSDS, 7b.CARE_ACTIVITY in FDF), using data item Community Care Activity Type, selecting 02 Assessment. Detailed guidance will be developed in future. However, organisations should be recording this activity locally.

In the CHS Sitrep, record activity under ‘(CYP) Community paediatric service.’

Community paediatrics: 4) Safeguarding; a) child protection medical assessment for physical abuse and neglect and b) child sexual abuse assessment.

Child protection medical assessment where this is suspicion of physical abuse, sexual abuse and neglect.

Description of the service

Community paediatrics services vary vastly dependent on commissioning arrangements, though will typically include safeguarding assessments including:

a) Child Protection Medical Assessment (CPMA) is a comprehensive medical assessment which is an essential component of the multi-agency investigation of child abuse. The assessment is part of the investigative process of alleged or suspected child abuse.

b) Child sexual abuse assessment as part of the investigative process of alleged or suspected child abuse. The general purpose of a medical assessment is threefold:

- To assist with the inter-agency assessment as to whether abuse has occurred.
- To ensure that any evidence which is collected and presented is of a high quality thus ensuring that the child/young person has the optimum level of protection and support.
- To ensure that the wider healthcare needs of the child/young person are fully identified, and arrangement

Who is the service for

A Child Protection Medical Assessment (CPMA) is conducted for children and young people (under 18 years old) when there are concerns about abuse or neglect. The assessment aims to identify any signs of physical, emotional, or sexual abuse and to ensure the child's health and well-being are safeguarded. Requests for CPMA will be in line with existing child protection strategy meeting guidance and process for CPMA requests.

A child sexual abuse assessment is conducted for children who are suspected of being victims of sexual abuse. This type of assessment helps professionals evaluate the child's well-being and determine whether any abuse has occurred. The assessment process is designed to be sensitive to the child's emotional state and is conducted by trained professionals.

Access and response times for first contact with service user

CPMA: **Emergency** cases require a medical exam **within 24 hours**, with an immediate strategy discussion. **Urgent** cases (e.g., recent abuse) should be assessed within **24-72 hours**, while **non-urgent** cases (e.g., historical concerns) should be seen within **5-10 working days.**

Sexual abuse assessment: If needed, a medical examination is conducted within **72 hours to a few weeks** after the alleged abuse to collect evidence and assess the child’s health.

Capabilities required at a population level

As safeguarding sits as a pathway in a community paediatrics service, figures shared are for broader community paediatrics service provision above.

Integration with wider health, education and social care system; services and agencies.

- **Health services**: working with general practice (including through provision of outcome reports and receipt of referrals), health visitors, school nurses, AHPs (including physiotherapists, occupational therapists and speech and language therapists), and Children and Young People’s mental health services and Neighbourhood MDTs for CYP, sexual health services and SARCs to address physical and mental health needs.
- **Local Police forces, Local Authority; social care** and **education**, working with local authorities to support safeguarding, looked after children's assessments, health needs of CYP with SEND, and the health needs of looked-after children ensuring coordinated care.
- **VCSE services**: signposting families to charities, support groups, and advocacy services that offer practical and emotional support.

The workforce delivering this core component should align to Neighbourhood footprints as appropriate.

Any specifics the service must meet for national requirements

- **Local Authorities**: Duty to investigate and assess when abuse is suspected, including conducting Section 47 inquiries (Children Act 1989).
- The **Royal College of Paediatrics and Child Health (RCPCH)** and **local safeguarding boards** recommend that CPMA assessments are conducted **without delay** to ensure child safety.

- If a CPMA is part of a Section 47 enquiry (where there are concerns a child is suffering or likely to suffer significant harm), the findings should inform an Initial Child Protection Conference, which must be held within 15 working days of the strategy discussion that initiated the Section 47 enquiry**.**

National data submission guidance

Record service or team referred to as '06 - Community Paediatrics' for children and young people (in table CYP102 Service or Team Type Referred To in CSDS, and table 6.b REFERRAL_SERVICE in FDF).

Where Safeguarding is the primary reason for referral, record ‘058 - Safeguarding’ (in table CYP101 Service or Team Referral in CSDS, and table 6a. REFERRAL in FDF)

Ensure date of birth is recorded (in the MPI table CYP001 in CSDS, and table 5a. CARE_MPI in FDF).

At present, there is no prescriptive national guidance on recording a) child protection medical assessment for physical abuse and neglect and b) child sexual abuse assessment. However, an assessment should be recorded in the care activity table, linked to the care contact in which it occurred (CYP202 in CSDS, 7b.CARE_ACTIVITY in FDF), using data item Community Care Activity Type, selecting 02 Assessment. Detailed guidance will be developed in future. However, organisations should be recording this activity locally.

In the CHS Sitrep, record under ‘(CYP) Safeguarding’.

Community paediatrics: 5) Children in care

Children in care: children in care Initial health assessments (IHA)

Description of the service

Community paediatrics services vary vastly dependent on commissioning arrangements, though will typically include safeguarding assessments including:

Medical assessment that covers CYP physical health, mental well-being, and developmental milestones. The IHA helps in detecting any existing medical conditions, nutritional deficiencies, immunisation status, and any other health-related issues that need attention. This is a legal requirement and an IHA should be requested as soon as a child becomes looked after.

Who is the service for

An **Initial Health Assessment (IHA) for Children in Care** is a comprehensive medical assessment carried out when a child enters the care system. It is a statutory requirement under **The Children Act 1989** and must be completed within **20 working days** of a child becoming looked after. ￼

Access and response times for first contact with service user

Must be completed within **20 working days** of a child becoming looked after.

Capabilities required at a population level

As children in care initial health assessment sits as a pathway in a community paediatrics service, figures shared are for broader community paediatrics service provision above.

Integration with wider health, education and social care system; services and agencies. ￼

- **Health services**: working with general practice (including through provision of outcome reports and receipt of referrals), health visitors, school nurses, AHPs (including physiotherapists, occupational therapists and speech and language therapists), and Children and Young People's mental health services and Neighbourhood MDTs for CYP to address physical and mental health needs.
- **Designated Doctor** and **Nurses for Looked After Children**, support the integration with the wider health, education and Social Care System
- Designated Clinical Officers (DCOs): Close working relationships with DCOs around compliance to SEND code of practice 0-25 years, SEND quality assurance and improvement and developing SEND specific knowledge and skills within the service.

- **Local Authority, education** and **social care**: working with local authorities to support safeguarding, looked after children's assessments, health needs of CYP with SEND, and the health needs of looked-after children ensuring coordinated care. Close working relationships with educational environments, nurseries, and educational psychologists to support children's learning and development. This includes engaging in strategic SEND partnership plans and providing health input for Education, Health, and Care Plans (EHCPs) and offering guidance to education settings about complex health needs.
- **VCSE services**: signposting families to charities, support groups, and advocacy services that offer practical and emotional support. ￼

The workforce delivering this core component should align to Neighbourhood footprints as appropriate.

Any specifics the service must meet for national requirements

NG205: A statutory health assessment for looked-after children and young people that must be completed within 20 working days of coming into care. It must be completed by a doctor who is registered with the General Medical Council and holds a licence to practise.

National data submission guidance

Record service or team referred to as '06 - Community Paediatrics' (in table CYP102 Service or Team Type Referred To in CSDS, and table 6.b REFERRAL_SERVICE in FDF). Where 'Looked after children' is the primary reason for referral, record '039 - Looked after children' (in table CYP101 Service or Team Referral in CSDS, and table 6a. REFERRAL in FDF).

Ensure date of birth is recorded (in the MPI table CYP001 in CSDS, and table 5a.CARE_MPI in FDF).

At present, there is not prescriptive national guidance to how to record IHA assessments in CSDS, however an assessment should be recorded in the care activity table, linked to the care contact in which it occurred (table CYP202 in CSDS, 7b.CARE_ACTIVITY in FDF), using data item Community Care Activity Type, selecting 02 Assessment. Detailed guidance will be developed in future. However, organisations should be recording this activity locally.

In the CHS Sitrep, record under '(CYP) Looked After Children teams'.

NHS England, Safeguarding also gather initial and review health assessment data for 'Looked after children' from commissioned providers via the NHS Data Collection Framework.

Children and young people’s audiology

Community children's audiology services assess, diagnose, and support the management of hearing loss in children. Services may provide early intervention, hearing aid fitting, ongoing support, and collaboration with healthcare and educational teams to ensure optimal communication and developmental outcomes.

Description of the service

The aim of hearing services for children is to improve the hearing related quality of life for those with hearing loss or impairment, tinnitus, hyperacusis and/or balance disorders. CYP audiology services provide assessment, diagnosis, intervention, and rehabilitation for hearing and balance disorders with more complex medical cases are referred to secondary care ENT or Audio vestibular Medicine services.

For CYP audiology services provision will vary dependent on commissioning arrangements, but may provide:

- Hearing assessments.
- Tinnitus and hyperacusis management, assessment and support.
- Hearing aid fittings and management.
- Ongoing monitoring for children at higher risk of hearing loss including (list not exhaustive or exclusive) CYP with Down syndrome, cleft palate, congenital cytomegalovirus, undergoing treatment with ototoxic medication.
- Referral pathways
    - Referral to ENT specialists, Audio vestibular Physicians or Paediatricians when serious conditions are suspected or for aetiology of hearing loss
    - Referral to CAMHS and Deaf CAMHS for emotional and mental wellbeing support for issues related to hearing loss including deaf identity and issues relating to tinnitus and hyperacusis
    - Onward referral to Teachers of the deaf when hearing loss is identified and treated with hearing aid technology.
    - Onward referral to CYP Speech and Language Therapy services
    - Referral to Cochlear implant services or Bone Conduction devices service when indicated.
- Transition pathway to adult audiology services.

Services should be able to provide ear wax management including removal by microsuction for patients where earwax affects audiometry and/or hearing aid fitting.

Providing advice and signposting about the SEND local offer. All local authorities are required to publish a Local Offer, setting out up to date information about services for children and young people with SEND. Health services must make sure that information on the local offer is accurate, easy to access and up to date.

Working jointly with families and including the voice of the child or young person in the planning of care and working with educational teams.

Where necessary, services will be required to engage in activity relating to resolution of complaints, mediation and SEND tribunal activity.

Services will need to engage in additional SEND training in line with the SEND Training Assurance Framework.

Who is the service for

Children (age cut off may vary) with suspected or confirmed hearing loss, tinnitus, or balance issues, and those requiring hearing aids, ongoing monitoring, or support for daily living. Support may be extended to age 25 for individuals with Education Health and Care needs.

Exclusion criteria:

- Sudden hearing loss (requires immediate ENT referral)
- Severe ear pathology (e.g., ear infections and ear trauma)
- Medical conditions requiring specialist ENT Audio vestibular Medicine, Paediatric or audiology services, such as cochlear implantation or complex vestibular disorders.

Access and response times for first contact with service user

The national 6 six-week diagnostic waiting time standard is mandatory and must be applied for audiology diagnostic tests.

The operational standard states that less than 1% of patients should wait 6 weeks or more for a diagnostic test (see national data submission guidance).

Follow on from newborn hearing screening

- All parents of babies referred for assessment following the newborn hearing screen who wish to proceed should be offered a full differential diagnostic within four weeks of screen completion or four weeks of corrected age if born early.
- Services should monitor the NHSP yield and rates over time and can receive training to do.

The British Academy of Audiology Quality standards in paediatric audiology set a number of waiting time targets for diagnostics, treatment and communication.

The Medium Term Planning Framework asks systems to actively manage long waits for community health services, reducing the proportion of waits over 18 weeks and developing a plan to eliminate all 52-week waits.

Capabilities required at a population level

- Integrated data systems to support risk stratification and shared care planning.
- Up to date knowledge and expertise in relevant health conditions and management
- Up to date knowledge of the available local services for community health
- Knowledge of medicines for relevant health conditions and how (prescriber and prescription) they can be obtained
- Up to date knowledge of equipment and technologies (such as hearing aids) for relevant health conditions (in multiple settings) and suppliers
- Up to date knowledge of legal frameworks such as safeguarding requirements and The Children's Act and SEND Code of Practice
- Specialist knowledge to be able to effectively triage calls
- Adequate capacity within the community to respond to requests for face-to-face support
- Clinical leadership skills and clinical supervision capability
- Assessments carried out by/ under the supervision of senior staff that have the expertise to explain and discuss results with families.
- Ability to work autonomously (but has awareness of when to seek further specialist support and advice)
- The provider shall ensure the maintenance of full, accurate, legible and contemporaneous records (including of professional registration, service quality management and audits)
- All audiology services should be UKAS IQIPS accredited to ensure the appropriate level of clinical quality and standards, if not accredited services should have an active plan to gain accreditation within 3 years.
- Sufficient trained workforce to meet population need.
- Provision of population specific services – eg communication provision, BSL/languages
- Provision of estates and equipment appropriate for the diagnostic provision of all service areas.

Integration with wider health, education and social care system; services and agencies.

Community audiology services often coordinate with:

- Education teams
- Local Children’s Hearing Services Working Groups
- Audio vestibular medicine
- Speech and Language Therapy services
- General practice (providing outcome reports and receiving referrals via direct access)
- Community Paediatrics services
- Health Visitors
- School Nurses
- Local NHS Community Service providers
- CAMHS
- Paediatric physiotherapy teams
- Independent and Third Sector providers e.g. NDCS
- Local Authority Social Services and Education Departments
- Children’s Hearing Services Working Group
- Education Health Care Plan (EHCP) teams
- ENT teams where onwards referral is required
- Adult audiology services for transition
- Designated Clinical Officers (DCOs): Close working relationships with DCOs around compliance to SEND code of practice 0-25 years, SEND quality assurance and improvement and developing SEND specific knowledge and skills within the service.

The workforce delivering this core component should align to Neighbourhood footprints as appropriate.

Any specifics the service must meet for national requirements

NICE guidance - Hearing loss in children

NICE guideline - Tinnitus: assessment and management

Commissioning framework - HLCF.pdf (england.nhs.uk)

Hearing loss action plan - NHS England Report Template 1 - long length title

RNID stats - Our facts and statements - RNID

RCGP toolkit - Deafness and hearing loss toolkit: Introduction | RCGP Learning

NHS England - Action Plan on Hearing Loss (What Works Guides and Joint Strategic Needs Guidance)

NHS England - Ear checks for children and young people in residential special schools and colleges in England

NHS England - Practising standards and clinical guidance – ear checks in residential special schools and colleges service NICE guidance Hearing loss in children

Commissioning framework - HLCF.pdf (england.nhs.uk)

Hearing loss action plan - NHS England Report Template 1 - long length title

RNID stats - Our facts and statements - RNID

RCGP toolkit - Deafness and hearing loss toolkit: Introduction | RCGP Learning

NHS England - Action Plan on Hearing Loss (What Works Guides and Joint Strategic Needs Guidance)

NHS England - Ear checks for children and young people in residential special schools and colleges in England

NHS England - Practising standards and clinical guidance – ear checks in residential special schools and colleges service

British Academy of Audiology – Quality Standards in Paediatric Audiology

Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance framework

GIRFT - ENT Referral Guideline CYP

A number of professional societies and bodies, including the British Academy of Audiology, British Society of Hearing Aid Audiologists, the British Society of Audiology the Health and Care Professions Council (HCPC) and Academy of Healthcare Science provide professional standards and registration for audiologists. Services may also wish to link with the National Deaf Children's society for information, advice and supportive services.

Areas must work with the Paediatric Hearing Services Improvement Programme to support the review and recall of babies and children at risk, and to address any harm caused by misdiagnosis or delayed diagnosis. NHS England » Paediatric Hearing Services Improvement Programme – operational guidance

National data submission guidance

Record service or team referred to as '17 - Hearing Service' (in table CYP102 Service or Team Type Referred To in CSDS, and table 6.b REFERRAL_SERVICE in FDF).

Ensure date of birth is recorded (in the MPI table CYP001 in CSDS, and table 5a.CARE_MPI in FDF).

In the Community Health Services Sitrep, record under '(CYP) Audiology services'.

The service must complete and report all quality metrics to the Integrated Care Board (ICB) and NHS England (NHSE). The service must also meet the reporting and quality standards required by relevant external bodies such as UKAS, the Care Quality Commission (CQC), and the Medicines and Healthcare products Regulatory Agency (MHRA). This includes active participation in audit and monitoring of service outcomes, and compliance with data requirements.

Audiology diagnostic tests should also be recorded in the DM01 collection, which collects activity and waiting times data on audiology diagnostic assessments. The distinctions between audiology data collected on the CHS SitRep and DM01:

- The DM01 collects data on NHS-funded audiology diagnostic assessments across **all settings**, collecting activity and waiting times data, reporting on >6-week and >13-week waits in line with diagnostic 6 week standard. For more information on recording of audiology assessment in DM01 see Reporting Diagnostics Activity and Waiting Times(DM01) to NHS England for Audiology.
- The CHS SitRep collects information on all in scope **community providers** covering community audiology services, with service lines split into children and young people (CYP) and adult services and collects waiting times data up to >104-weeks.

Children’s community nursing

Description of the service

Nursing Need

The overarching aim of the community children’s nursing (CCN) service is to provide specialist nursing and clinical interventions to any child or young person with health needs that can be managed at home, educational settings or in community locations. A CCN Team should ensure the child is seen as close to home, as is practicable. For many children this will include in the educational environment to reduce impact of missed school time.

Models of a CCN service are

- Hospital outreach/generalist CCN service
- Hospital outreach or specialists
- Community base team
- Hospital at Home (virtual ward model)

Overarching – pathway design should move away from task-based care and towards improving personalised outcomes (measures) for the baby, child or young person (BCYP).

Outcomes should include children able to access education and early years setting

Four groups of children and young people are[1]:

- children with acute and short-term conditions
- children with long-term conditions
- children with disabilities and complex conditions, including those requiring continuing care and neonates; and
- children with life-limiting and life-threatening illness, including those requiring palliative and end-of-life care

[1] NHS At Home: Community Children’s Nursing Services (NHS 2011)

Children’s Community Nursing Pathways

These overarching pathways can be considered as a blended approach to ensure individualised care and are not an exhaustive list of conditions.

Pathway, expected time on caseload	**Type of intervention**	**Expected outcome**
Acute & short-term needs		

Short term need, <3months	IVABS, chemotherapy, hospital at home (virtual ward, injections, eczema	Discharge to general practice or initial referrer Or Transfer to acute or long-term condition pathway
Acute need, 3months – 3years	Oncology, those awaiting cardiac surgery, babies receiving oxygen due to prematurity	Discharge to referrer, transfer to long term condition pathway
Long term and life-limiting conditions		
Short term need	Needs that may arise from the long-term condition but don’t have ongoing nursing care need. I.e. children with stable epilepsy who have a change in their condition	Discharge to referrer or to lifelong need pathway
Lifelong need	Examples include diabetes patients using technology, short gut syndrome, epilepsy (including Seizure management planning), juvenile arthritis, bowel and bladder care	Discharge to referrer. Transition to adulthood May overlap with complex case pathway
Complex disability, Lifelong on caseload with regular needs review.	Ongoing nursing need that requires regular nursing intervention i.e. Neurodisability, long term ventilation, hypoxic ischaemic encephalopathy, spinal muscular atrophy	Transition to adulthood May overlap with palliative care pathway
Palliative Care, Often runs concurrently to existing pathway	Any condition showing gradual deterioration requiring palliative intervention.	Stabilisation, support on previous pathway End of life care pathway
End of life care, Usually, ~2 weeks but flexible to child’s needs	Deteriorating and unstable condition that requires end of life care, symptom control and where required, parallel planning	Stabilisation, support on previous pathway. End of life care.

Core services are:

- Assess children and young people’s symptoms, recognise sickness or deterioration and take the first steps in the management of conditions, including informing general practice or hospital paediatricians as appropriate.

- Core community nursing provides holistic assessments, care planning, and co-develops treatment and escalation plans for CYP and families that require community nursing interventions and care
- Core CCN Services should provide clinical/nursing interventions, which includes wound care including tissue viability, administering medications, passing NG tubes and respiratory support, venepuncture, maintaining central venous access devices and administering Intravenous medications as well as symptom and pain management
- Co-ordinate the care planning and management of children with long term conditions, disabilities and complex needs to prevent accident and emergency department attendances and unplanned admissions
- Co-ordinate the nursing care planning and management of community palliative care and end-of-life needs
- Advocating for the child/young person to ensure their needs are safeguarded at all times
- Ensure robust infection control procedures/ policies
- Support technology dependency (i.e. tracheostomies, oro/nasal-pharyngeal care, enteral feeding, long term ventilation)
- A CCN Team can lead multi-agency and system wide meetings relating the child or young person (Team around the Child, MDT discussions, EHCP, Personal Health Budgets and Advanced Care Planning/RESPECT)
- CCN Teams work in specialist community pathways as required (i.e. Metabolic/ Endocrine/ Genetic abnormalities)
- Provide a comprehensive (nursing) training programme to enable children and young people who require health interventions inclusion in education services and *provide training in delegation into social care short break provision, where appropriate.*
- To include:
    - Developing competence, and ensuring education courses are fit for purpose
    - Standardising competencies required for role and promoting work-based learning
    - Delegated tasks from registered to non-registered practitioners with robust competency frameworks
- To provide clinical information including care plans to contribute to the ICB Children and Young People's Continuing Care multi-agency forum or decision panel.
- EHCP/ Early identification key for Children with SEND
- Transition - see 3) Special educational needs and disability (SEND) , including education, health and care statutory services and support throughout transition and preparing for adulthood. Providing advice and signposting about the SEND local

offer. All local authorities are required to publish a Local Offer, setting out up to date information about services for children and young people with SEND. Health services must make sure that information on the local offer is accurate, easy to access and up to date.
- Working jointly with families and including the voice of the child or young person in the planning of care.
- Where necessary, services will be required to engage in activity relating to resolution of complaints, mediation and SEND tribunal activity.
- Services will need to engage in additional SEND training in line with the SEND Training Assurance Framework.

Services are provided in a diverse range of community settings that may include a child or young person’s home, early years settings, family hubs, child development centres, schools (special and mainstream), colleges, respite care and clinics. Telephone and online support/consultations are offered where appropriate.

Children and Young People's Continuing Care

In addition to the above, where CCN Services provide Children and Young People's Continuing Care, core services should include:

- Provide reliable and sustainable care packages for children and young people who are technology dependent in conjunction with the local ICB's Children and Young People's Continuing Care team.
- Multi-agency and/or multidisciplinary groups working with the family to support the nominated children and young people’s health assessor to produce the child or young person’s continuing care options which are safe and effective, taking into account the child or young person’s and their family’s preferences.
- To provide clinical information including care plans to contribute to the ICB Children and Young People's Continuing Care multi- agency forum or decision panel.
- Consideration for how continuing care integrates with SEND provision, and universal and specialist health provision.
- Where commissioned, provide nursing care in home, educational, residential settings school nursing and support workers, based upon assessed need, for individuals eligible for Children and Young People's Continuing Care in conjunction with the Children and Young People's Continuing Care Team.
- Support the management, purchasing, monitoring and maintaining clinical equipment this is needs assessed.

Who is the service for

This service is for any baby, child or young person with any nursing need that requires clinical care support and interventions in the community setting to avoid unnecessary hospital appointments (including outpatients), admissions to hospital and primary care visits to allow improved outcomes and keep care as close to home as possible.

CYP including Children in Care and their families with short and longer term additional and complex health needs will also need additional support from many of the other service describe in the CYP Core descriptions, such as:

- Community Paediatrics, including SEND
- CYP MSK
- Palliative care and end of life care
- Children and Young People's Continuing Care/ NHS Continuing Health Care
- Tissue viability and wound care, working with specialist TVNs.
- General practice

Children and Young People in education settings regardless of the type of setting, Local Authority or non-Local Authority funded.

Access and response times for first contact with service user

Same day and 2 weeks, therefore unlikely to hold a formal waiting list.

Some children will require ongoing clinical input to keep them well and out of hospital. This may require proactive action to seek families less likely to access services. Some of these children will have periods where they don’t require active input but remain on the caseload.

Other children will come on to the caseload for a time limited period to address a specific need.

This requires proactive caseload review and consistent application to ensure equitable access.

Capabilities required at a population level

- Working towards or have obtained Specialist Qualification in Practice (NMC) children’s community nursing.
- CCN Team should provide nursing services that can be an alternative to acute admissions, support emergency department avoidance (with medical oversight) and expedite discharge

- CCN Teams should develop advanced practice models to increase and develop autonomous practice to provide clinical leadership across the MDT, making and enabling independent and complex decisions.
- Where service need assessment indicates, advanced clinical practice roles to support integration to the MDT and Neighbourhood Health Services.
- Children and Young People’s Continuing Care (CYPCC).
- Ongoing development and learning regarding new technologies that are helping advance clinical practice
- Safeguarding children's skills and capability
- Prescribing controlled drugs/medications
- Administering IVs
- Setting up and maintaining syringe drivers
- Advanced communication skills
- Care and support planning, including advance care planning
- Provision of equipment
- Understanding of children’s community care framework
- Delivery of care in various settings including but not limited to educational environments, home, nursery, short breaks and hospice settings.
- Provide nursing oversight into short breaks for those where needs cannot be delegated/ nursing decisions needed in care or those with symptom management needs.
- Up to date knowledge of legal frameworks such as safeguarding requirements and the Children Act 1989, the Children Act 2004 and the Children and Families Act 2014 and the SEND code of practice: 0-25 years
- Requirement to provide EHC needs assessment and advice
- Competency and capabilities; supporting technology dependencies, holistic care planning, advanced plans of care in the context of end-of-life planning (inc. parallel planning), supporting those that meet Children and Young People's Continuing Care and support hospital avoidance and expedite discharge and save general practice/primary care appointments where possible.
- Ensure personalised care to identify strengths and needs to encourage placing the CYP at the centre, with the aim to improve health outcomes and improve coordination of care
- Promote Personal Health Budgets
- Utilise frameworks to determine health outcomes, as this identifies CYP priorities such as communication methods, mobility, pain & self-care.
- Utilise Advanced Nurse Practitioner/ Nurse consultant roles to enhance clinical nursing tasks (i.e. prescribing, complex IV therapies, symptom and pain management) as these are essential for robust clinical leadership

- Population health intelligence to identify high-risk individuals and areas of high demand.
- Integrated data systems to support risk stratification and shared care planning, ideally based on an integrated EPR.
- Workforce planning tools to deploy teams according to local population need.
- Capabilities in addressing social determinants of health, including housing, transport, loneliness, and nutrition.
- Digital maturity to enable remote monitoring, and telehealth as necessary
- Knowledge and expertise in relevant health conditions and management
- Knowledge of the available local services for community health
- Knowledge of medicines for relevant health conditions and how (prescriber and prescription) they can be obtained
- Knowledge of equipment for relevant health conditions (in multiple settings) and suppliers
- Up to date knowledge of legal frameworks such as safeguarding requirements and The Children's Act
- Specialist knowledge to be able to effectively triage calls
- Adequate capacity within the community to respond to requests for face-to-face support
- Communication skills and training for people with complex long-term conditions,
- Clinical leadership skills and clinical supervision capability
- Ability to work autonomously (but has awareness of when to seek further specialist support and advice.

Integration with wider health, education and social care system; services and agencies.

Each team needs to work with the universal community health offer the multi-disciplinary team and integrate in clinical pathways in Integrated Neighbourhood Health Teams.

The workforce delivering this core component should align to Neighbourhood footprints as appropriate.

Teams work alongside wider professional network support CYP and their families including social care (and early help), education, acute paediatrics and primary care and hospices and short break provisions.

Teams should work strategically with adult community services (i.e Continuing Health Care) to ensure transition destination is identified early and appropriate planning is undertaken.

(*The CYPCC transition into adult services guidance has been approved and is currently with Publications).*

Health

- Children's Community Nursing services should be highly integrated with Special school nursing teams/services.
- Working closely with community paediatrics and sharing outcomes with referrers. MDT approaches and integrated therapy teams with Occupational Therapists, Speech and Language Therapists and Physiotherapists, nutrition and dietetics, non-registered AHP / therapy staff and other specialist teams such as Children and Young People's Continuing care teams and Pharmacy for medicines management.
- Designated Clinical Officers (DCOs): Close working relationships with DCOs around compliance to SEND code of practice 0-25 years, SEND quality assurance and improvement and developing SEND specific knowledge and skills within the service.
- Children's Continuing Care/Adult CHS
- Neighbourhood MDTs for CYP
- General practice as a potential referral source
- Acute- CCN's working in collaboration can support emergency department avoidance (with medical oversight)

Education

- Service Level Agreement that underpins delegation of tasks to establish clear governance for those tasks being undertaken in educational environments.
- To maintain clinical oversight and clinical risk monitoring as appropriate
- Working jointly with teachers, TAs and senior leadership teams, they support settings to deliver targeted interventions, provide staff training and advice, and deliver interventions.
- Liaising with education professionals such as Specialist teachers, Education Psychologists, SEN service.

Social Care working alongside:

- Social Workers working with children in care, with disabilities, or those at risk of neglect.
- Child Protection Services, addressing communication issues linked to all forms of abuse and neglect.
- Family Support Services supporting families with children and young people with disabilities, including short break providers.

Strategic co-production with parent carers and young people: Services will need to work with voice organisations and groups such as parent carer forums and children and young people's participation groups.

Suggested KPI's for local data reporting and evaluation

- Number of children on caseload
- Number of children receiving active clinical interventions
- Clinical interactions (described as home visits, school visits, telephone advice to family, telephone advice to professionals, training intervention with family, training intervention with professionals)
- Care hours provided.
- Clinical intervention where the alternative was hospital attendance
- Clinical intervention where the alternative was a general practice appointment.
- Clinical intervention that enabled earlier discharge from hospital (quantified as bed days saved)
- School absence avoidance (a reflection of the training of school staff to enable children to access education)
- Patient Outcome Measures (defined by pathway destination)
- Nurse prescribing episodes/number of nurse prescribers

Any specifics the service must meet for national requirements

Children and young people's continuing care national framework; Process for assessing the needs of children and young people whose complex needs cannot be met by universal or specialist health services.

Children and young people's continuing care national framework - GOV.UK

National framework for NHS continuing healthcare and NHS-funded nursing care - GOV.UK

Overview | Transition from children's to adults' services for young people using health or social care services | Guidance | NICE

Improving NHS children's community nursing services - GOV.UK

NHS England » Service specifications for palliative and end of life care: Children and young people (CYP)

Maximising the role of Community Children's Nursing teams

Section 23 Children and Families Act 2014, notifying the local authority of children under the compulsory school age who in the opinion of the ICB or Trust has SEND and may require SEND provision.

Under regulation 6(1)(d) of the SEND Regulations 2014, when a local authority (LA) carries out an EHC needs assessment, they must seek medical advice and information from a health professional.

Children and Families Act and SEND Code of Practice:

Must provide advice for Education, Health, and Care Needs Assessment (EHCNA) within a statutory timeframe of 6 weeks

National data submission guidance

Record service or team referred to as '38 - Children's Community Nursing Service' (in table CYP102 Service or Team Type Referred To in CSDS, and table 6.b REFERRAL_SERVICE in FDF) or more appropriate service type where delivered by community nursing e.g. Nursing and Therapy teams support for long term conditions.

In the CHS Sitrep, record under 'CYP Community nursing services (planned care and rapid response teams)' or more appropriate service type where delivered by community nursing e.g. Long Term Conditions Case Management Service

Children and Young People's Continuing Care (CYPCC) data is part of the- All-age Continuing Care (AACC) Data Set v2.0. Providers must ensure reporting for activity related to CYPCC to this data set.

CYPCC is part of a national AACC programme. AACC is an umbrella term, created by NHS England, to cover key aspects of NHS AACC, where AACC refers to the following commissioned services:

- NHS Continuing Healthcare (NHS CHC) including Fast Track (EoL)
- NHS-funded Nursing Care (FNC)
- Joint packages of health and social care as an outcome of an assessment for NHS CHC
- Children and Young People's Continuing Care (CYPCC)

Special school nursing

Highly integrated with Children’s community nursing services.

Description of the service

Special school nursing (SSN) services provide a core set of nursing functions to provide proactive, personalised, and holistic nursing care in special education settings, and advice/support to community children’s nursing teams on supporting children in mainstream settings with similar needs.

The overarching aim is to provide specialist nursing and clinical interventions to any child or young person with health needs that can be managed within the setting. Including most often physical, complex health needs and learning disability.

The core purpose is to:

- Deliver a caseload management approach, to enable long term health planning for children and young people to fully engage with all elements of their education.
- Provide advice and clinical care planning for children attending education settings who require regular medical interventions in the setting.
- Provide support to mainstream settings with children with similar complexity to ensure safe and effective delegation of delegated tasks
- In conjunction with paediatricians, specialist teams, school nursing teams and acute nursing teams, ensure safe delegation of tasks to carers or educational environment staff to administer. The team hold the clinical responsibility for the tasks delegated in line with the NMC and RCN guidance on delegation and DfE guidance on meeting pupils' medical needs in school.
- Where the model is on-site, provide on-site clinical presence, from a responsive team for children and young people with unpredictable needs
- Work with Public Health Nursing teams to ensure public health nursing interventions can be made in the Special school environment for example vaccinations.
- Early years: work with Health Visiting and early years providers to support transition to special school settings, with the wider MDT.
- Provide a clinical advisory role to the wider MDT.
- Providing health advice for Education, Health and Care (EHC) needs assessments and annual reviews.
- Providing advice and signposting about the SEND local offer. All local authorities are required to publish a Local Offer, setting out up to date information about services for children and young people with SEND. Health services must make sure that information on the local offer is accurate, easy to access and up to date.

- Working jointly with families and including the voice of the child or young person in the planning of care.
- Supporting young people to transition into adult health services, including working with the young person to develop a transition plan (see 8.54 of the SEND code of practice) including managing their own conditions where appropriate and transitioning to adult services.
- Where necessary, services will be required to engage in activity relating to resolution of complaints, mediation and SEND tribunal activity.
- Services will need to engage in additional SEND training in line with the SEND Training Assurance Framework.

Suggested KPI's for local data reporting and evaluation

- Number of children on caseload
- Number of children receiving active clinical interventions
- Clinical interactions (described as home visits, school visits, telephone advice to family, telephone advice to professionals, training intervention with family, training intervention with professionals)
- Care hours provided.
- Clinical intervention where the alternative was hospital attendance
- Clinical intervention where the alternative was a general practice appointment.
- Clinical intervention that enabled earlier discharge from hospital (quantified as bed days saved)
- School absence avoidance (a reflection of the training of school staff to enable children to access education)
- Patient Outcome Measures (defined by pathway destination)
- Nurse prescribing episodes/number of nurse prescribers

Suggested inclusion of a QI statement around suggested metrics – prescribing incidents, ambulance call, admission avoidance such as seizure management/ suction/ tracheostomy changes due to blockages that would be emergency avoidance. Enteral feeding; emergency interventions of gastrostomies.

Who is the service for

Children and Young People in special education settings regardless of the type of setting, Local Authority or non-Local Authority funded.

This will include children placed in out of area and/or residential educational settings.

SSNs should work with CCNs to provide an advisory role to the MDT to support children to access nursery and early years settings.

Access and response times for first contact with service user

Access to this service is through planning for entry to school in liaison with CCNs who are usually already supporting children with nursing need. Annual review of need as a minimum is required, for some children this will be more frequent.

For some settings where clinical needs are high, *on-site support* may be necessary, sometimes requiring an immediate response.

In-reach may require a same day response.

The Medium Term Planning Framework asks systems to actively manage long waits for community health services, reducing the proportion of waits over 18 weeks and developing a plan to eliminate all 52-week waits.

Capabilities required at a population level

- Working towards or have obtained Specialist Qualification in Practice (NMC) children's community nursing.
- Children and Young People's Continuing Care - a professional skilled in assessing CYP health needs e.g. RNC, RNLD
- SSN Teams should develop advanced practice models to increase and develop autonomous practice to provide clinical leadership across the MDT, making and enabling independent and complex decisions.
- Integration with the wider MDT is necessary to ensure clear governance
- Ongoing development and learning regarding new technologies that are helping advance clinical practice
- Safeguarding children's skills and capability
- Administering IVs
- Advanced communication skills
- Care and support planning, including advance care planning
- Involved in assessing need for and arranging the provision of equipment
- Wound Care with support from Tissue Viability Teams
- Understanding of children's community care framework
- Delivery of care in various settings including but not limited to educational environments, home, nursery, short breaks and hospice settings.
- Strong understanding of frameworks that support children such as SEND code of practice, Children and Families Act.

- Work with MDT to support technology dependencies, holistic care planning, advanced plans of care in the context of end-of-life planning (inc. parallel planning), supporting those that meet Children and Young People's Continuing Care and support hospital avoidance. Expedite return to educational environments where appropriate.
- Ensure personalised care to identify strengths and needs to encourage placing the child at the centre, with the aim to improve health outcomes and improve coordination of care
- Promote Personal Health Budgets
- Utilise frameworks to determine health outcomes, as this identifies child’s priorities such as communication methods, mobility, pain & self-care.
- Population health intelligence to identify high-risk individuals and areas of high demand.
- Integrated data systems to support risk stratification and shared care planning.
- Workforce planning tools to deploy teams according to local population need.
- Capabilities in addressing social determinants of health, including housing, transport, loneliness, and nutrition.
- Digital maturity to enable remote monitoring, and telehealth as necessary
- Knowledge and expertise in relevant health conditions and management
- Knowledge of the available local services for community health
- Knowledge of medicines for relevant health conditions and how (prescriber and prescription) they can be obtained
- Knowledge of equipment for relevant health conditions (in multiple settings) and suppliers
- Up to date knowledge of legal frameworks such as safeguarding requirements and The Children’s Act
- Specialist knowledge to be able to effectively triage calls
- Adequate capacity within the community to respond to requests for face-to-face support for health conditions
- Communication skills and training for people with complex long-term conditions,
- Clinical leadership skills and clinical supervision capability
- Ability to work autonomously (but has awareness of when to seek further specialist support and advice)
- Support young people to help them prepare for adulthood.
- Up to date knowledge of legal frameworks such as safeguarding requirements and the Children Act 1989, the Children Act 2004 and the Children and Families Act 2014 and the SEND code of practice: 0-25 years.

Integration with wider health, education and social care system; services and agencies.

Each team needs to work with the universal community health offer the multi-disciplinary team and integrate in clinical pathways in Integrated Neighbourhood Health Teams.

The workforce delivering this core component should align to Neighbourhood footprints as appropriate.

Health

- Special school nursing teams/services should be highly integrated with Children's Community Nursing services.
- Working closely with community paediatrics and sharing outcomes with referrers. MDT approaches and integrated therapy teams with Occupational Therapists, Speech and Language Therapists and Physios, nutrition and dietetics, non-registered AHP / therapy staff and other specialist teams such as Children and Young People's Continuing care teams and Pharmacy for medicines management.
- Designated Clinical Officers (DCOs): Close working relationships with DCOs around compliance to SEND code of practice 0-25 years, SEND quality assurance and improvement and developing SEND specific knowledge and skills within the service.
- Requirement to provide EHCP needs assessment and advice
- Children's Continuing Care/Adult CHS
- General practice as a potential referral source
- Neighbourhood MDTs for CYP

Education

- Service Level Agreement that underpins delegation of tasks to establish clear governance for those tasks being undertaken in educational environments.
- To maintain clinical oversight and clinical risk monitoring as appropriate Working jointly with teachers, TAs and senior leadership teams, they support settings to deliver targeted interventions, provide staff training and advice, and deliver interventions.
- Liaising with education professionals such as Specialist teachers, Education Psychologists, SEN service.

Social Care working alongside:

- Social Workers working with children in care, with disabilities, or those at risk of neglect.

- Child Protection Services, addressing communication issues linked to all forms of abuse and neglect.
- Family Support Services supporting families with children and young people with disabilities, including short break providers.

Strategic co-production with parent carers and young people: Services will need to work with voice organisations and groups such as parent carer forums and children and young people's participation groups.

Any specifics the service must meet for national requirements

School nursing: public health services

Guidance for putting in place public health services for children and young people from 5 to 19 years. School nursing: public health services - GOV.UK

Overview | Transition from children's to adults' services for young people using health or social care services | Guidance | NICE

Supporting pupils with medical conditions at school - GOV.UK

Section 23 Children and Families Act 2014, notifying the local authority of children under the compulsory school age who in the opinion of the ICB or Trust has SEND and may require SEND provision.

Under regulation 6(1)(d) of the SEND Regulations 2014, when a local authority (LA) carries out an EHC needs assessment, they must seek medical advice and information from a health professional.

Children and Families Act and SEND Code of Practice:

Must provide advice for Education, Health, and Care Needs Assessment (EHCNA) within a statutory timeframe of 6 weeks.

National data submission guidance

Record service or team referred to as '38 - Children's Community Nursing Service' (in table CYP102 Service or Team Type Referred To in CSDS, and table 6.b REFERRAL_SERVICE in FDF).

Also record ORGANISATION IDENTIFIER (EDUCATIONAL ESTABLISHMENT) (in the MPI table CYP001 in CSDS, and table 5a.CARE_MPI in FDF).

Palliative care and end of life care – infants, children & young people

Palliative care is an approach that improves the quality of life of people of all ages and their families facing the difficulties associated with life-threatening or life-limiting illness. End of life care is provided to people of all ages who are likely to be in the last 12 months of life. Both include care of the dying baby, child or young person.

Babies, children and young people (BCYP) with life limiting or life-threatening conditions who have palliative and end-of-life care needs require support through a whole system approach, with care and support provided by the right professional, at the right time, in the right place, including access out of hours and specialist-level palliative care when needed. BCYP palliative care needs fluctuate, so a flexible and responsive model of care is required to encompass all phases and complexities of their illness or condition. BCYP require access to a wide variety of care from a range of providers working together through integrated models including primary, community, acute and urgent care services, as well as education, social care, voluntary sector providers and hospices.

Description of the service

Access to palliative care and end-of-life care should not depend on diagnosis or overall prognosis and can be provided at any stage of a baby, child or young person's illness. Services with the competencies to offer neonatal & paediatric palliative care will support and care for babies, children and young people and their families at any point from diagnosis or recognition, through active treatment, including that aimed at cure, to end-of-life care and bereavement.

Babies, children and young people's palliative and end-of-life care needs and complexity can fluctuate, requiring an agile and flexible model of care. Care is provided through universal care providers including primary, community, acute and urgent care services, as well as specialist-level palliative care services when needed. Delivered in all settings in the community, including family homes, community hospitals (for young people up to the age of 25) and hospices, typical universal activity includes but is not limited to:

- Symptom management support, holistic support, pre and post bereavement support, personalised care and support planning, including advance care planning
- MDT provision of care Inpatient provision, including symptom management, end of life inpatient care. and specialist respite services for CYP who are medically complex or technology dependent.
- Support to CYP undergoing transition to adult services.

Typical **specialist level palliative care** activities include, but are not limited to:

- advanced symptom management: including understanding of rare disorders and their pathways
- specialist medical and nursing support, available 24/7, for hospices, acute trusts, community palliative care teams and tertiary centres
- specialist equipment in the home (where not included in Children and Young People's Continuing Care arrangements) [may be commissioned on a case-by-case basis where unique needs are identified]
- identification of those with complex grief and at ‘high risk’, and their signposting/referral to appropriate local and/or specialist bereavement services.
- education and training programmes across care settings, including bespoke patient-specific training of professionals in the use of specialist paediatric palliative care equipment, eg community patient-controlled analgesia and drug infusion devices.

Who is the service for

Babies, children and young people with life-limiting or life-threatening conditions, and their families. Different services will have different acceptance criteria for age. The recommendation is that all services use the definition of age as from birth up to 18th birthday as a minimum standard, but where appropriate they work towards implementing services for those up to 25. This is especially important when considering service users with learning disabilities and transition requirements.

End of life Care service refers to care that helps all those likely to be in the last 12 months of life with advanced, progressive and terminal conditions to live as well as possible until they die. It enables the supportive care needs of both the individual and the family to be identified and met through the last phase of life and into bereavement. It includes the physical care, management of pain and other symptoms and provision of psychological, social care, spiritual and practical support.

Specialist Palliative Care Service includes care and support delivered by a multi-disciplinary team with the requisite qualifications, expertise and experience to improve quality of life **for people with progressive life-limiting illness with the most complex needs** (for example complex symptoms, rehabilitation or family situations and ethical dilemmas regarding treatment and other decisions). Input from Specialist Palliative Care professionals must be based on the person’s needs and not their diagnoses.

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and assessment and treatment of symptom control i.e. pain physical, psychosocial and spiritual. Palliative care is often delivered in conjunction with other therapies that are intended to prolong life, and includes those investigations needed to better understand and manage clinical complications. Palliative care can be provided by a range of health and social care staff and may be done alongside treatment intended to reverse particular conditions.

Access and response times for first contact with service user

Babies, children and young people with life limiting or life-threatening conditions may already be in receipt of care from Community Children's Nursing Teams depending on local arrangements.

Babies, children and young people with a life-limiting condition are cared for by a multidisciplinary team that includes members of the specialist paediatric palliative care team. This requires identification of need and referral to specialist services where available, with a named medical specialist who leads and coordinates their care, opportunity for advance care planning and 24-hour access to both children's nursing care and advice from a consultant in paediatric palliative care.

Initial assessment and triage of need to be undertaken within 24 hours of referral or a change in need being identified.

Capabilities required at a population level

Required capabilities include, but are not limited to:

- Prescribing controlled drugs
- Administering IVs and subcutaneous medications
- Setting up and maintaining syringe drivers
- therapeutic and rehabilitative palliative care, maximising independence and social participation in line with wishes and preferences (e.g. physiotherapy, speech and language therapy, occupational therapy)
- Advanced communication skills
- Care and support planning, including advance care planning and parallel planning
- Non-invasive and invasive ventilation
- Care of advanced interventions such as tracheostomies, TPN, PEGs and oral secretion management
- Complex symptom management, including pain management
- Multi-agency care coordination
- Knowledge and expertise in the assessment and management of palliative care and end of life care needs, including symptom management
- Knowledge of the available relevant local services for palliative care and end of life care

- Knowledge of medicines for PCEoLC and how (prescriber and prescription) they can be obtained
- Knowledge of equipment for PCEoLC needs (in multiple settings) and suppliers
- Knowledge and competent use of the local personalised care and support planning systems, including Personal Health Budgets, and documents including symptom management and advance care plans
- Up to date knowledge of legal frameworks such as Mental Capacity act, Lasting Powers of Attorney, Advance Decision to Refuse Treatment, safeguarding requirements, learning disabilities training (e.g. Oliver McGowan Mandatory Training) and The Children's Act

Integration with wider health, education and social care system; services and agencies.

All services – both statutory and voluntary –must work collaboratively and closely together to deliver a truly integrated service model. In the delivery of an integrated service, interdependence exists between the Specialist Level Palliative Care services and:

- primary and community providers – general practice, community children's nurses and out of hours services and where commissioned, district nurses
- other multidisciplinary specialist teams and allied health professionals
- rapid response team
- social care services – both in hours and out of hours
- other providers of children and young people PCEoLC services: statutory and voluntary
- providers of acute care
- urgent and emergency care services, including NHS 111 and ambulance services
- providers of adult palliative care
- providers of services for babies, children and young people with life-limiting and life-threatening conditions
- children with disabilities social care teams
- health visiting/school health nursing
- Children's Continuing Care/Adult Continuing Health Care, use of fast track in end of life care.
- equality and inclusion leads
- Local authority services, education services including and all education settings.

Designated Clinical Officers (DCOs): Joint working relationships with DCOs around compliance to SEND code of practice 0-25, SEND quality assurance and improvement and developing SEND specific knowledge and skills within the service.

The workforce delivering this core component should align to Neighbourhood footprints as appropriate.

Any specifics the service must meet for national requirements

NICE Guidelines:

- End of life care for infants, children and young people with life-limiting conditions: planning and management (NICE NG61)
- End of life care for infants, children and young people (NICE QS160)

NHS England:

- Palliative and End of Life Care. Statutory Guidance for Integrated Care Boards
- Specialist palliative and end of life care services. Children and young people service specification
- Universal Principles for Advance Care Planning

National Palliative and End of Life Care Partnership

Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026

National data submission guidance

Record service or team referred to (in table CYP102 Service or Team Type Referred To in CSDS, and table 6.b REFERRAL_SERVICE in FDF).
as:

- 14 - End of Life Care Service'- see definition above.
- or '47 - Specialist Palliative Care Service'- see definition above.

Ensure date of birth is recorded (in the MPI table CYP001 in CSDS, and table 5a.CARE_MPI in FDF).