Service Specification No.	
Service	**Children's Community Nursing Services**
Commissioner Lead	
Provider Lead	TBC
Period	TBC
Date of Review	TBC

1. Population Needs

1.1 National/local context and evidence base

The national context and evidence base can be identified within the following documents:

- National Service Framework for Children, Young People and Maternity 2004
- Making it better for Children and Young People 2007
- Healthy Lives: Brighter Futures 2009
- Every Child Matters: Change for Children 2004
- Aiming High for Disabled Children: Better support for families 2007
- Transforming Community Services: Ambition, Action, Achievement Transforming services for Children, Young people and their families 2009
- RCN Well Child Better at Home Campaign 2008
- Independent review Children's Palliative Care 2007
- Better Care: Better Lives
- CCN Review
- Kennedy Review
- NHS White Paper

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local defined outcomes

- Care provided in the child's home or other appropriate settings. Thus reduction of psychological effect of hospitalisation and care in a clinical setting.
- Nursing and psychological support to child and family to facilitate social inclusion and prevention of hospitalisation.
- Reduction in disruption of normal family life.
- Provision of equitable service to children as adult services.
- Provision of health education, information etc. in an environment conducive to concordance.
- Facilitation of the mental health and well-being of the family.
- Prevention of admission and re-admission to hospital and facilitate the timely discharge of children from hospital. Support for families caring for a sick child at home to develop self-efficacy.
- Seamless transition between acute and primary care
- Where they wish to do so, children are provided with end of life care to enable them to die at home

- Improved patient & parent/carer satisfaction
- Parents feel supported and empowered to care for their children at home
- Children and young people are supported in developing self-care abilities
- Effective transition to adult services is supported
- The service shall contribute to EHC assessments for CYP known to the service, this will include providing reports/information regarding identified health needs and provision required in line with the specified timeframes
- The service shall review EHC draft plans for which they have provided information to quality assure the accuracy of the information included in line with the specified timeframes
- The service shall engage and work in conjunction with the Designated Clinical Officer (DCO) for Special Educational Needs and Disabilities (SEND) to ensure compliance with statutory requirements

3. Scope

3.1 Aims and objectives of service

Aims

To provide Community Children's Nursing services to Children and Young People residing within the boundaries of Staffordshire with varying health needs ranging from acute, complex and life limiting/life threatening. To work in an integrated way with acute hospitals:

- To deliver planned and unplanned care including assessment and treatment in the child and family's own home.
- To work in partnership with all providers of paediatric care including: GP's, acute care, Primary Care teams, local pharmacists and voluntary and third sector providers.
- To reduce the number of avoidable admissions to secondary care and presentations to emergency portals.
- To reduce length of stay in the acute setting, by delivering prescribed care safely and effectively within the child and family's home.
- To provide support and health education in order to facilitate self-care and independence. This may include providing training and support around specific children and participation in sharing of skills, knowledge and expertise.
- Work closely with commissioners of services to develop of best practice guidance and service quality standard.
- To work in partnership with the child and family, providing real choice as to how and where they receive nursing care and support.
- Encourage children and young people to gain control of their care including guidance regarding personal budget options including Continuing Health Care and Personal Health Budgets for the delivery of health care services
- The service shall be appropriate for a diverse population – i.e. ethnicity, linguistically, culturally, geographically, economically and educationally.

Objectives

- To ensure that primary and secondary care services, social services, education services and other agencies have easy access to child health expertise through clear referrals criteria and pathways.
- To ensure that children and their families once referred into the service have easy access to expert nursing advice and support through clear and consistent communication pathways including arrangement of direct admission for children when required
- To ensure that the guidance and advice given to children and families is consistent with best practice, primary care and secondary care practice through integration, communication and professional development and sharing of expertise.
- To enable parents and children to participate as active partners in health care by the use of care

plans and pathways.

- To develop appropriate and relevant service standards against whist quality of community children's services can be audited and evaluated.
- To develop appropriate data collection methods to facilitate clinical audit.
- Act as lead professional and advocate as appropriate
- A holistic approach to managing the child's health needs and supporting the family towards self-efficacy: including care co-ordination, liaison with other healthcare professionals as required, including 3rd sector, local authority and tertiary hospitals
- Monitoring and observation in agreement with the child/family.
- Participate in shared care with hospital and with General Practice
- Ensure parents have clear contact points for accessing support
- Support and contribute to SEN assessment and care management approach.
- Support Continuing Care team in the assessment of needs for funding requests. Complete appropriate section of the Decision Support Tool (DST) for children with continuing care needs.
- The team may contribute to the training for some invasive procedures to parents, health, education and social services carers.

3.2 Service description/care pathway

The Community Children's Service provides specialist nursing support in the child's own environment, in partnership with the child, family, carers and other professionals.

Complex Care

- A holistic all-encompassing approach to care throughout the child and family's journey.
- Specialist nursing input aimed at avoiding admission to acute setting wherever appropriate and safe to do so.
- Assessment of acute nursing needs and care management
- Care co-ordination as required by the child/family to optimise improved outcomes.
- To act as lead professional/key worker as appropriate
- Assessment and management of pressure areas at home
- Monitor and ensure appropriate symptom management and pain control throughout assessment and intervention
- Specialist nursing input aimed at avoiding admission to an acute setting wherever appropriate and safe to do so.

Palliative Care

- Assessment of nursing need for any child identified as having a life limiting/life threatening condition as identified in the Together for Short Life Palliative Care Categories and supported by a Paediatrician.
- A holistic all-encompassing approach to care throughout the child and family's journey.
- Agree and support an end of life care plan
- Access continuing care funding to facilitate 24 hour nursing support in accordance with continuing care funding protocols in the south and east of Staffordshire
- Monitor and ensure appropriate symptom management and pain control throughout assessment and intervention
- Assessment and management of pressure areas at home
- Access to 24 hour telephone support and advice in the north of Staffordshire
- Access to specialist psychology support and intervention in the north of Staffordshire
- Access to short break in-home respite services in the north of Staffordshire
- Individualised Care planning including and Advanced Care Plan where deemed appropriate.
- Access to 24 hour symptom management for end of life care.
- Access to respite provision in northern Staffordshire
- Access to psychology services with consent of the child/family in northern Staffordshire

Hospital Avoidance

- Assessment of acute nursing needs and care management
- Local access to specialist nursing input delivering high quality unplanned care including assessment and treatment in a domiciliary setting aimed at avoiding admission to acute setting wherever appropriate and safe to do so.
- Facilitate a timely discharge through the delivery of nursing intervention, care and support.
- Assessment and Care management of acute illness/conditions in agreement with referrer.
- Individualised care planning supporting self-efficacy
- Monitoring and Observation in agreement with the child/family.
- Referral into other services if/as deemed appropriate in agreement with the child/family.

Constipation Service

To manage symptoms of constipation through advice/support and healthcare interventions thus avoiding admission to acute setting wherever appropriate and safe to do so, in the north.

Non Direct Interventions

- The team may contribute to the training for some invasive procedures to parents, health, education and social services carers.
- Liaison with multi-agency professionals including local & tertiary centres.
- Contribute to co-ordinating continuing care packages including identifying the clinical needs of the child and family, with the referring hospital.
- Management of equipment and consumables including maintenance of equipment provided by the Community Children's Nursing Service.
- Opportunistic and planned public health education and health promotion e.g. smoking cessation, healthy eating.
- Provision of specialist advice and training to Education, social care and voluntary organisations and any partner services.

Respite Service

This service is available to children and young people identified with a life limiting/life threatening condition who are registered with a GP within the boundaries of Stoke on Trent and North Staffordshire CCGs. Home based respite care is available according to the Respite Matrix assessment scoring system. Staff are supported and trained by the community children's nurses.

Psychology Service

Home-based psychology assessment, support and intervention is available to children and young people and their families identified with a life limiting/life threatening condition who are registered with a GP within the boundaries of Stoke on Trent and North Staffordshire CCGs.

Care Planning and Coordination

The Community Children's Nursing Service shall be responsible for ensuring an assessment is carried out at the initial contact and reviewed in a timely and appropriate manner.

A care plan shall be negotiated and agreed with all parties including the child and family. This shall be based upon local and national standards, policies, protocols and guidelines and shall take into account the wishes of both the child and family.

Parental consent and responsibilities shall be explicit within the care plan.

The Community Children's Nursing Service shall, where appropriate, contribute to any statutory assessments undertaken by or required by Specialised Services (social care), continuing care and Education.

3.3 Response time/detail and prioritisation

Service will respond within three hours to a referral for a child/young person with an acute illness.
Service will respond within 2 working days to a referral for a child/young person with a non-acute condition

Transition

Transition shall be planned where transition is clinically indicated and where adult services are commissioned. Transition should include active participation and co-operation from the child's medical team in both primary and secondary care. Proactive engagement with adult services (Health and/or Specialist Services including Social Care) shall commence as the child reaches 14 years of age.

From the age of 16-19, if the service user is consenting and only where the nature of illness or presenting condition dictates, a referral to Adult Community Nursing Services shall be made. Any such cases shall be discussed and agreed with the service user in the first instance and the care plan discussed and agreed between the Community Children's Nursing Service and the Adult Services.

An individual transition care plan between paediatric and adult-orientated health services must provide coordinated and uninterrupted healthcare to avoid negative consequences. Adequate time must be given to access appropriate training and procurement of equipment/consumables and engagement with adult services.

Multi agency support must be provided to young people and their families of which The Community Children's Service shall contribute to ensure successful transition. The child/family will benefit from help in developing skills in communication, decision making, assertiveness and self- care, helping them to manage social, educational and employment opportunities and challenges and develop the independent living skills which underpin fulfilment and well-being.

3.4 Population covered

Children who are registered with a GP within the boundaries of the six Staffordshire CCGs.

3.5 Any acceptance and exclusion criteria and thresholds

Referral Criteria

- The child or young person is aged 16 years or under, with the following exception:
- up to 18 years if already under the care of or referred by a paediatrician/children's urgent care team
- up to 19 years if they have a learning disability, although this may be negotiated with Adult Community Services, and may require a joint approach dependant on the presenting condition.
- For any new period of acute illness the child/young person will need to have been assessed by a medical professional before the referral can be accepted
- The child must be thought to have a specific health care/nursing need, either acute or more complex in nature that requires the expertise of a community children's nurse.
- The child and family must be aware of the referral and have given informed consent.
- Medical Management of the child remains the responsibility of the referring GP, Consultant or Tertiary Care specialist.
- The service has direct referral route to Consultant or Acute Secondary care provider as necessary and appropriate.
- If a referral to the community children's nursing service is not accepted, the child and family shall be directed to another service via the initial referrer.

- Referrals will be received from any medical professional

Exclusion Criteria

- Children who require emergency or urgent medical attention
- Children who require dry dressings – post operative
- Dispensing of medication or the routine collection and delivery of prescriptions
- Administration of routine oral medications
- Children with long term ventilation
- Children with an unstable medical condition
- Children with mental health problems which may affect their ability to take medication or undertake personal care.
- Requests to check Plaster of Paris
- Requests for equipment where there is no identifiable complex health care need
- Children who need assistance with personal care
- Assessment of social care needs

3.6 Interdependence with other services/providers

Stakeholders and interdependencies shall vary for individual services and service users but shall include:

- Paediatricians
- General Practitioners
- Acute Hospitals including regional and national centres
- Allied Health Professionals
- CAMHS
- Learning Disability Services
- Health Visitors
- Targeted Intervention Service
- Public Health Advisory Service
- Equipment Services
- Parents and Carers
- LA – Education
- LA – Specialised Services
- Voluntary Organisations
- Hospice
- Adult Services

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

- NHS at Home: Community Children's Nursing Service, March 2011 Dh124900CNN
- National Service Framework for Children, Young People and Maternity 2004
- Every Child Matters: Change for Children 2004
- Transforming Community Services: Ambition, Action, Achievement Transforming services for Children, Young people and their families 2009

5. Applicable quality requirements and CQUIN goals

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

6.	Location of Provider Premises
6.1 The Provider's Premises are located at: Provided in most appropriate and safe setting for the child and family – Home, Clinic, Children's Centre and School.	
7.	**Individual Service User Placement**
N/A	