SCHEDULE 2 – THE SERVICES

Service Specifications

Service	Community Children's and Young People's Service
Commissioner Lead	Karon Foulkes, Head of Maternity and Children's Commissioning and Transformation, N&N ICB
Period	April 2022 – March 2024

Introduction

This specification incorporates the following elements of community service provision for children and young people with acute and additional health needs, including disability or complex needs and those requiring palliative or end of life care:

Community children and young people's healthcare (ICCYPH) service – this element of the specification is applicable to all clinical discipline specific elements detailed in the sub-specifications as listed below. Following provider engagement with families, this service is now called the Community Children and Young People's Service (CCYPS) and shall be referred to as such within this specification.

CCYPS sub-specifications:
A – Children and young people's community physiotherapy and occupational therapy
B – Speech Language and Communication Needs service for preschool children (Early Intervention)
C – Children and young people's community speech and language therapy
D – Children and young people's community nursing
E – Children and young people's community phlebotomy

The Community Children and Young People's Healthcare (CCYPS) service will be delivered for children and young people registered with GPs in the Nottingham and Nottinghamshire Integrated Care System i.e. the Place Based Partnership areas of: Mid Nottinghamshire (Mansfield and Ashfield , Newark and Sherwood), South Nottinghamshire (Rushcliffe, Nottingham North and East and Nottingham West) and Nottingham City. If a child has school-based needs and attends a Nottinghamshire school but lives out of area, the local service will deliver the support in school but the local ICB where the child lives will cater for their broader care. The provider is to have a case by case conversation with other provider parties to ensure that this is agreed and operationalised. Any issues with this should be escalated to commissioners.

This specification requires the provider(s) to commit to continual improvement, transformation and innovation by working collaboratively across interfaces, including but not limited to acute health services, community and universal health and social care services, adult health and social care services, education, third sector services and commissioners with the aim of integrating care for children and young people.

The vision is to enable children and young people with acute and additional health needs, including disability and complex needs, to have their health needs met wherever they are. The services will support the child's life choices rather than restrict them and improve the quality of life for children and their families and carers.

This includes the following overlapping and interrelated groups:
Children and young people with...

- Life limiting and life threatening conditions and illness, including those requiring palliative and end of life care.
- Disabilities and complex conditions including those requiring continuing care and neonates.
- Long term conditions (this excludes the activity delivered by condition specific Clinical Nurse Specialists based within Acute Trusts).
- Acute and short term conditions (requiring interventions over and above those provided by universal and primary care services, to avoid hospital admission and/or reduce length of stay).

In Nottinghamshire, a child or young person is considered to special educational needs (SEN) or disability if they need extra help with for a range of needs in the four areas of SEND described in the SEND Code of Practice: 0 to 25 years (2014):

- Communicating and interacting
- Cognition and learning
- Social, emotional and mental health difficulties
- Sensory and/or physical needs

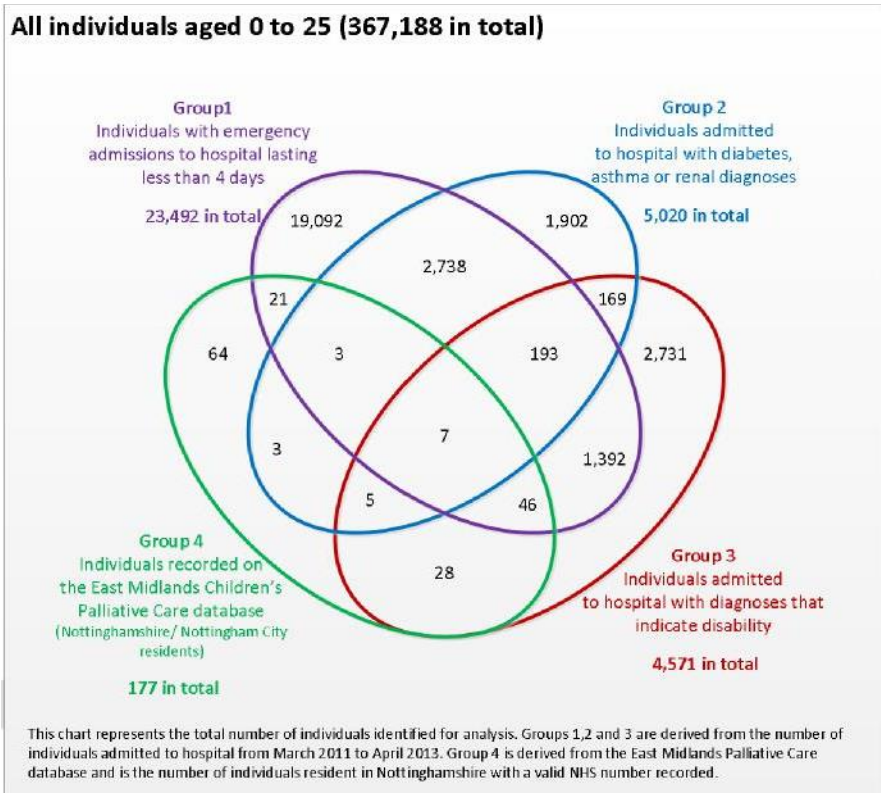
During their development and/or the progression of their condition or illness individual children and young people may and often do move between and overlap these groups. Equally there are children and young people who require input from only one clinical discipline within the coordinated service.

The vision reflects the Nottinghamshire Families' Statement of Expectations (see appendix 1), developed with young people and families in Phase 1 of the Nottinghamshire Integrated Children and Young People's Healthcare Programme (2013), which provides guiding principles for developing, commissioning, delivering and reviewing the service.

1. Population Needs

1.1 National and Local Context and Evidence Base

Data surrounding the number of children and young people who will have a need for this service is very difficult to define, as can be seen by the diagram below (from Phase 1 Report) which illustrates the overlap between the different groups of children and young people who will have a need for this service.



Within this context the estimates of those children experiencing some form of disability is outlined below.

Estimated numbers of children and young people experiencing some form of disability in Nottinghamshire County (Nottinghamshire JSNA 2014):

Thomas Coram Research Unit (2010) Based on 2014 population and a prevalence of 3-5.4%	6598-11882 (0-24 year olds)
Child and Maternal Health Observatory (2000) Census (2011) CYP with life limiting long term health problems	7,615 (0-19 year olds) 7891 (0-15 year olds)

In November 2018, there were 7,080 children and young people aged 0-18 living in Nottinghamshire and 3,050 living in Nottingham City who were claiming Disability Living Allowance. 43% of school age children and young people in the city are from black and minority ethnic groups and 35% are living in poverty. There has been increased demand for places in special schools, increased numbers of children and young people with special education needs and increased referrals and contacts with specialist children and young people's community therapy services.

The table below shows the number of pupils with special educational needs in state funded primary, secondary and special schools in Nottinghamshire and Nottingham City (Local Authority school census data, January 2019).

	City		**County**	
	Total pupils with SEN	**Pupils with EHC Plans**	**Total pupils with SEN**	**Pupils with EHC Plans**
Primary School	4,134	103	7,830	261
Secondary School	2,342	111	3,866	273

Special School	620	611	1,071	1,068
Total	7,096	825	12,767	1,602
% of total state funded pupil population	15%	1.8%	10%	1.3%

NB – what these figures cannot tell us is what proportion of these children have clinical needs which may be associated with this service.

Across the population of children and young people with additional needs the following needs have been identified:

- There is a lack of co-ordinated support for children and young people with complex needs and disability and their families as shown in recent engagement work done.
- There is an increase in need and an ongoing requirement to demonstrate value for money as well as ensuring equity of access and service provision, taking account of population needs, geography and finances.
- More children with a severe disability and complex needs are living longer (Healthy Lives, Brighter Futures 2009), owing to new interventions and technology.
- Disabled children/young people and those with complex needs often have higher safeguarding needs.
- There are multiple providers/teams working to different processes (e.g. assessments, care plans), policies and procedures and different IT systems, which on occasion may result in duplication / lack of efficiency and effectiveness (resulting in a negative impact on children, young people and families).
- There are too many acute and emergency attendances and admissions for conditions and illness that could be treated at home or admission avoided. Evidence suggests peak times are weekends and during the after-school period.

2. Outcomes

2.1 NHS Outcomes Framework Domains and 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 safe environment and protecting them from avoidable harm**	✓

2.2 Local Defined Outcomes

The local CCYPS Service Outcomes and Quality Framework has been developed to reflect and support the delivery of the Families Statement of Expectations (see appendix 1). This framework sits within the context of the South Notts and Mid-Notts transformation programmes.

3. Scope

3.1 Aims and objectives of the Service

The Community Children and Young People's Service will provide a high-quality evidence based coordinated service that anticipates and responds to the needs of specific groups of children and young people (see introduction above). CCYPS will support the delivery of the recommendations from the Joint Nottinghamshire CCYPS Programme Phase 1 recommendations (Appendix 2). As such the objectives of the service are to:

- Minimise duplication, ensure effective use of resources, and optimise the collective benefit to children/young people and families from services and informal carers (e.g. family and friends) involved in their care – the child's "circle of support".
- Work with commissioners and partners to ensure high quality, clinically and cost effective, evidenced based and value for money services are delivered within agreed care pathways.
- Enable children and young people with acute and additional health needs, including disability and complex needs, to have their health needs met.
- Deliver care that 'follows the child/young person' to any location where they would reasonably be expected to be.
- Provide co-ordinated community healthcare services to improve the health, wellbeing and life chances of children, young people and their families.
- Reduce length of acute stay, facilitate discharge and/or avoid admission where clinically appropriate.
- Deliver a seamless service that is centred around children, young people and their families, contributing to maximising independence and quality of life including pro-active support and planning for transition.
- Empower children and young people to be actively involved in making decisions about their care, evaluation and co-production of the service, including but not limited to, deciding who to have present at consultations.
- Provide streamlined access and equity of care provision for children, young people and their families.

- Offer choice wherever possible, including access to Personal Health Budgets
- Ensure a sustainable and motivated workforce with the right skills in the right place at the right time, every time.
- Ensure effective safeguarding is embedded across the provision.
- Provide early intervention, prevention and treatment that aims to reduce avoidable admissions and/or exacerbations.
- Contribute to improved emotional and mental health and wellbeing of children, young people their parents/carers and the wider family.
- Develop and implement pathways to ensure effective and supported transition to adulthood/adult services in collaboration with health, social care, education and third sector partners and commissioners.
- Proactively offer provision in a clear and transparent way to ensure families do not have to ask for the care and support that they need.

3.2 Service Description / Care Pathway

3.2.1 Service Overview

The service will provide coordinated and sustainable specialist children/young people's care delivered via a flexible and agile network of community-based services, including nursing care and therapies.

The service will provide streamlined access and coordinated assessment, treatment and review, supported by personalised care plans, shared records and communication across coordinated care pathways so that families experience a seamless service that is centered around the child / young person and family promoting privacy and dignity, independence and quality of life.

Care will 'follow the child/young person' and will include in-reach into hospital and out-reach to any location where the child/young person would reasonably be expected to be e.g. school.
The service will deliver a streamlined service consisting of:

- Children and young people's community occupational therapy
- Children and young people's community physiotherapy
- Children and young people's community speech and language therapy
- Children and young people's community nursing
- Children and young people's community phlebotomy
- Care co-ordination
- Transfer of care (facilitating discharge and avoiding admission)
- Training and competency assessment
- Information, advice and support

The service will be provided within a life-course, multi-disciplinary, multi-agency whole system approach, illustrated in Appendix 3, working with and alongside other services including, but not limited to, paediatricians, acute services, health visitors, midwives, school nurses, GP's, social care and education, third and independent sector services, including adult services during transition. The service will proactively deliver support in line with the Equality Act 2010 and other relevant legal frameworks.
The coordinated service will be underpinned by:

- Effective leadership and a streamlined management structure, including appropriate specialist clinical leadership.
- A culture of continual improvement and innovation.
- Open and transparent collaborative relationships and co-production with commissioners, partners, children, young people and families.
- A multi-skilled and multi-sector workforce.
- Streamlined assessments, reviews and clinical activity.
- Best practice and evidence based care
- Shared information and records and effective use of systems and processes e.g. administration tasks.
- Regular and effective communication with GPs
- Innovative use of technologies.
- Streamlined and consistent performance and outcome monitoring and reporting
- The families statement of expectations (see appendix 1) and a child centred, family focused approach

3.2.2 Transformation and Continual Improvement

This specification requires the provider to commit to continual improvement, transformation and innovation by working collaboratively across interfaces, including but not limited to acute health services, community and universal health and social care services, adult health and social care services, education, third sector services and commissioners with the aim of integrating care for children and young people.
The provider will:

- Continually work towards improvement and development across the whole system to achieve better experience and outcomes for children, young people and their families.
- During the term of this specification fully co-operate in reviewing and improving/re-designing care delivery at the request of and with the involvement of the Commissioners, partners and children, young people and parents/carers. This will inform future service requirements.

- Ensure that there are effective systems and processes to support the collection, analysis and timely reporting (to commissioners) of high quality accurate and meaningful data and information to demonstrate effective care delivery and outcomes and to build an evidence base to inform future assessment of need and commissioning arrangements.
- Continually improve the quality of care delivery, for example, in response to audit (undertaking and completing the audit cycle), user and staff feedback (complaints, compliments, suggestions) and incidents.
- Continually review and be aware of relevant new and emerging guidance and recommendations and developments (e.g. local care pathways) and take the appropriate steps to assess and improve care delivery to achieve current evidence based best practice.
- Work with commissioners to implement the palliative care funding currency.
- Produce and implement plans that demonstrate how it will improve performance in achieving outcomes and meet increasing needs within its resources.

3.2.3 Care Pathway

The provider will be expected to develop/adopt specific clinical care pathways and guidelines to support evidence-based, cost and clinically effective service delivery and best practice.

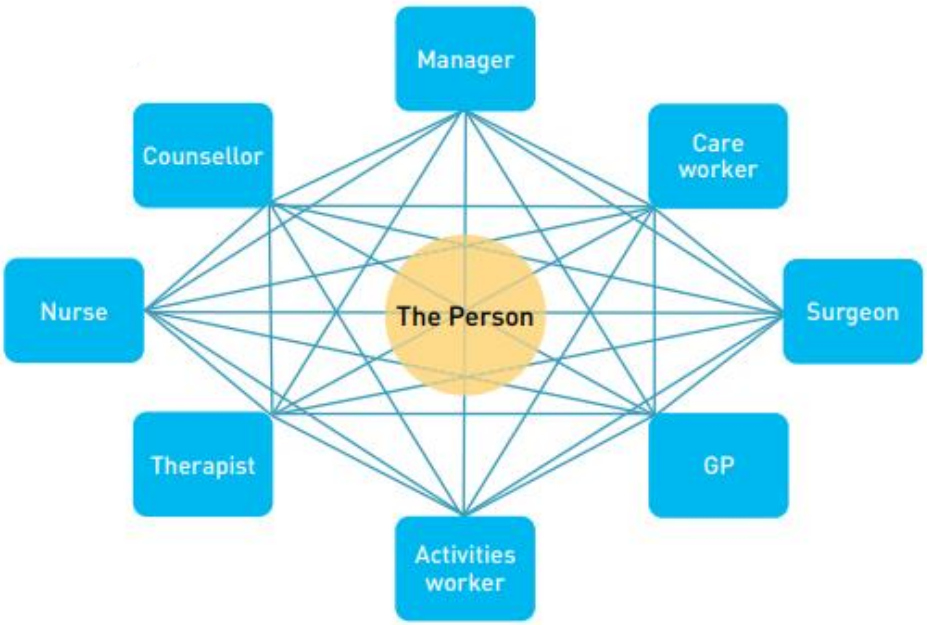
The coordinated service will be delivered within a whole system approach.

Across the care pathway including but not limited to referral, triage, assessment, care planning, delivery of interventions, review and transition there will be effective communication with the child or young person, their parents/carers, the GP, the referrer and other appropriate professionals regarding progress, next steps and care delivery.

Interpreting services will be used wherever appropriate and communication with children, young people and families will be appropriate for individual's age and development, culturally sensitive and in a format that suits the individual child or young person and their family.

The pathway/model for the service is included below

Model Pathway



3.2.4 Service Description

This section describes the care delivery of the coordinated service in which the following clinical discipline specific elements are embedded. Clinical detail for each element can be found in sub-specifications:

A – Children and young people's community physiotherapy and occupational therapy
B – Speech Language and Communication Needs service for preschool children (Early Intervention)
C – Children and young people's community speech and language therapy
D – Children and young people's community nursing
E – Children and young people's community phlebotomy

A) Access and referral management

- There will be a clear point/s for receipt of electronic, telephone and (where available) choose and book referrals, with specialist referral templates incorporating all relevant information.
- There will be an opportunity for supporting information, such as previous assessments, to be shared as part of this

- Appropriate referrals will be accepted from GP's, community and acute health and social care professionals, education, third sector services
- Self-referrals will be accepted where appropriate.
- Telephone advice to support referrals will be available.
- All referrals will be acknowledged and information will be shared with the child or young person, their parent/carer, the GP and referrer regarding the referral and assessment processes. This will take place within a maximum of 7 working days (Monday-Friday, excluding bank holidays).
- The provider will advise and support the wider children and young people's workforce, including GPs, to make appropriate referrals.
- The provider will be expected to work collaboratively with Nottinghamshire County Council and Nottingham City Council to ensure the most appropriate services are accessible for disabled children and to constantly improve accessibility to services for disabled children.
- Where children and young people are declined at the point of referral the provider will support the family and the referrer to understand the reasons they are not eligible for this service and support them to access alternative services or support. This may include making a referral to these services on behalf of the child/young person as appropriate and/or supported access/signposting to the Local Offer/s.

B) Triage

- Referrals will be triaged by appropriately skilled professionals
- Additional information will be collected by the service, including copies of previous assessments, in order to complete triage.
- Triage will be supported by a clear governance process (such as detailed algorithms, clear assessment criteria and information sharing agreements).
- A Common Assessment Framework (CAF) or Early Help Assessment Form (EHAF) will be initiated where appropriate
- Triage will be available where appropriate within the working week to facilitate safe timely discharge from the acute setting and/or support avoidance of acute admission/attendance where clinically appropriate. The provider will prioritise assessment and provision of care based on clinical need.
- Core information will be recorded once and shared appropriately across referral, triage, care planning and delivery of interventions.

C) Assessment Process

- An appropriate holistic assessment will be undertaken, informed by information gathered at triage.
- Contact with the CYP and/or family will be made to assess and advise or offer treatment within the 13-week RTT. This will be prioritised based on clinical need. Same day assessment will be available where an immediate response is deemed necessary.
- Coordinated assessments will be undertaken for children and young people who may require input from a range of disciplines/agencies and assessment will be carried out by multi-skilled professionals.
- Assessment will be carried out in conjunction with the multi-agency team wherever possible and the provider will be expected to pro-actively facilitate this.
- Interdependencies and links with paediatricians and acute services will be key to the effective delivery of the service, including assessment, treatment and review.
- The views and needs of the child/young person and their parents/carers will be at the heart of assessment.
- Assessment will be needs driven and not dependent on receipt of a specific clinical 'diagnosis'.
- The emotional and mental health of the child or young person, their parents/carers and the wider family will be considered across the pathway.
- Referrals and signposting may be made to other agencies and services with appropriate consent.
- Where children and young people are discharged at the point of assessment the provider will support the family and the referrer to understand the reasons they are not eligible for this service and support them to access alternative services or support. This may include making a referral to these services on behalf of the child/young person as appropriate and/or supported access/signposting to the Local Offer/s.

D) Personalised care plan

- A personalised care plan will be developed informed by the assessment, including assessment of risk.
- The care plan will ensure the needs and preferences of the child or young person and their parents or carers are at the centre of care planning using 'support planning' principles.
- The care plan will use best practice and evidence based interventions including use of validated evidence based approach/tools to assess, identify and agree individual outcomes.
- The care plan will include clear outcomes using 'goal setting' principles, based on evidenced based tools.
- The care plan will be available to share electronically as appropriate with appropriate safeguards and compliance with information governance requirements and shall be owned by the child or young person and their parents/carers.
- The care plan will be shared with professionals and consent obtained where appropriate.
- There will be a case load holder for each child or young person available to contribute to multi-agency planning and review.

- The provider will contribute to Education Health and Care (EHC) plans within the mandated timescales when required.

E) Care delivery

- Interventions will be delivered by a multi-disciplinary workforce with multi-skilled individuals in order to use resources as effectively as possible and avoid multiple contacts for children/young people and their parents/carers.
- Coordinated interventions will be delivered for children and young people who may require input from a range of clinical disciplines, as detailed in the sub-specifications.
- Care delivery will aim to minimise disruption to the lives of the child/young person and their parents/carers and will be culturally sensitive. Care delivered will be flexible to respond to the emerging or changing needs of the child or young person and to have minimal disruptive impact on access to education, social and family activities.
- Provision of recommended equipment will be via the Nottinghamshire Integrated Community Equipment Loans Service (ICELS), children's continuing care *and*/or wheelchair services.

Delivery of care will commence as clinically appropriate. Same day intervention will be available where this is deemed necessary

F) Transfer of Care (facilitated discharge and avoiding admission)

Advice and clinical interventions will be provided to children and young people, parents/carers, acute and community health services and professionals with the aim of:

- Supporting discharge from acute services
- avoiding unnecessary admission or attendance at Emergency Department (ED)
- providing continuity of care during acute stays, ensuring good communication and information sharing

The provider will develop care pathways to facilitate this, including working collaboratively with acute services to develop in-reach working to streamline handover of care to community services. This will include flexibility to deliver intensive interventions in the community to support step-down from acute services or prevent an avoidable admission, and the delivery of in-reach support to ensure delivery of interventions during hospital admissions.

The service will establish strong relationships with General Practice and Healthy Family Teams.

Children's continuing care

The provider will proactively work with other services to refer children and young people with highly complex health needs for children's continuing care assessment in line with the Nottingham City and/or Nottinghamshire County children's continuing care pathways.

The provider will contribute to assessment and review of children and young people with continuing care needs and ensure interventions delivered under this service are coordinated with the delivery of packages of continuing care. This will include proactively supporting commissioners and providers of children's continuing care and working to integrate care pathways wherever possible.

Children and young people's liaison

The provider will:

- Facilitate all children/young people accessing health care provision to be safeguarded by effective communication between all healthcare providers and other agencies.
- Promote and support the transition of care between acute and community services in order to facilitate early discharge from hospital.

Training provision

The provider will establish, coordinate and deliver accredited training packages from the below embedded list of core offers, for a range of agencies and carers in the community, including parents and carers. The aim is to ensure that children and young people with additional health needs receive safe and effective care to meet their needs wherever they may reasonably be expected to be.

List of training subjects

- Administration of a Prefilled Subcutaneous Injection
- Anaphylaxis awareness and use of an AAI
- Anaphylaxis awareness and use of an AAI – Train the trainer
- Asthma awareness
- Attention Definicit Hyperactivity disorder Awareness
- Autistic Spectrum Disorder Awareness
- Epilepsy Awareness
- Epilepsy Rescure Medication – Buccal Midazolam
- Gastromy Awareness including Blended diet
- Gastromy balloon water change Awareness – Delivered to residential areas only
- Gastrojejunal Awareness
- Medication AdministrationAwareness

- Medication Administration – Controlled Drugs
- Nasgastric Tube Awareness
- Oxygen Awareness
- Oral Suction Awareness
- Recognising Childhood Illness – delivered to residential areas only
- Tracheostony Awareness
- Vagal Nerve Stimulation for paediatric epilepsies

Annual Refreshers

- Epilepsy Awareness
- Eplisepsy Resucue Medication: Buccal Midazolam
- Gastromy Awareness including Blended Diet
- Medication Administration Awareness

The provider will develop and deliver accredited 'train the trainer' programmes where appropriate and manage and undertake competency assessment.

The provider will develop and deliver comprehensive training packages to ensure that the wider workforce have the skills and competency to meet the needs of children and young people. This may include staff in education settings, early years settings, short breaks services, youth and play services, leisure services, universal services, transport, direct payment/personal health budget providers and parents/carers and the extended family. Training may be delivered to individuals or groups.

Training will be delivered and assessed in line with an appropriate approved training framework. The training for some specific clinical tasks will be delivered by an appropriate clinician e.g. physiotherapist for deep suctioning.

Pathways will be established to other established training such as diabetes and asthma , where it is the responsibility of other providers or specialist services.

Where the training requested is patient specific, settings/ organisations will not be charged for this even those which are deemed to be profit making organisations (e.g. private early years settings). Profit making healthcare agencies will be charged. The operational management of this will be determined by the provider. The frequency and prioritization of subjects for generic training fall under the remit of the provider.

Behavioural, emotional and mental health and wellbeing

The service will support the emotional, mental health and wellbeing of the child/young person, their parents/carers and the wider family, including siblings via effective prevention, identification, support and referral to appropriate services.

Emotional, mental health and wellbeing will be embedded in service delivery in line with NHS England guidance regarding parity of esteem. The workforce will be appropriately skilled to recognise those at risk of developing emotional, mental health and wellbeing issues, the signs of emotional ill health, and know how to access specialist support. This will include effective liaison with emotional, mental health and wellbeing services e.g. child and adolescent mental health services, adult mental health services, the pathway for children and young people with behavioural, emotional and mental health needs (Nottingham City) and/or the concerning behaviours pathway (Nottinghamshire County).

Patient engagement and participation

Patient engagement and participation will be embedded in service delivery, design and co-production. The provider will ensure that continual review and evaluation of the service via effective two-way engagement with the children, young people, their parents/carers is embedded in the care delivery.

At all stages the provider will ensure communications about assessment and treatment are clear and timely and that the child or young person and their parents/carers have opportunity to feedback.

Promotion and support of self-care

Training and support for parents will be embedded in service delivery in order to skill parents and carers in identification, early intervention and prevention with the aim of avoiding exacerbation. Parents, carers and children and young people (where appropriate) will be skilled and competent to manage their own or their child or young person's condition.

In order to support parents and carers there must be appropriate communication and planning to enable them to manage conditions in the best way possible. To support this, information should be available and easy to access including access to appropriate electronic resources, care plans and records. Electronic resources may include self-care videos, recorded consultations and online trusted advice. Empowerment of the service users themselves and their parents/carers in the delivery of this self-care should be demonstrated with consideration given to the whole spectrum of those who provide this care.

Supporting Education

The provider will deliver high quality evidence-based care to:

- For children and young people attending a special needs school or a mainstream school (where the child or young person has additional health needs) assessment will be delivered prior to admission and support will be available to schools in the development of care plans, which the school will lead on and be responsible for. Pathways will be developed with education and social care to facilitate this, prevent delays to children and young people accessing educational placements and ensure the delivery of provision supports learning.
- Support the child or young person's health needs to enable them to access education and participate in family and social and leisure activities in settings of their choice.
- Work in a partnership with Public Health Nursing services to provide public health interventions for children and young people with complex and additional needs.
- Contribute to maximizing the child/young person's potential for independence, including pro-active support and planning for transition for those already known to the service and for those referred in for transition purposes (pathway to be developed with schools).

Education, Health and Care Plans (EHCPs)

The service will contribute/provide a written report to EHCPs wherever required. This may include assessment of needs and contribution to the development of plans with a clear focus on outcomes for children and young people. The provider will work within the agreed statutory timeframes for EHCPs and in line with the Nottingham City or Nottinghamshire County pathways. This may include providing support to the family and attending person centered review meetings/multi agency meetings (MAMs) to plan and review the child or young person's health and care needs and package of care.

EHCP Stage 2 Requests

When a request for health advice in relation to a child or young person's SEND is received from the local authority during stage 2 of the EHCP process, a response from the provider must be returned to the local authority within 6 weeks of receipt into the CCYPS SPA. A report must be produced for all cases seen by the service within the previous 12 months. For cases not seen by the service in the previous 12 months, the provider can respond through appropriate channels that they are no longer involved with the child or young person and giving the dates of any previous involvement. Any health provision recommended by the provider in their report must be specific and time limited where appropriate with specified outcomes.

EHCP Reviews

For children and young people known to the service with an EHCP in place, the provider has a duty to provide a report for any scheduled EHCP review 2 weeks prior to the review taking place. It is beneficial for practitioners to attend EHCP reviews wherever possible, however if they cannot attend a report must be submitted.

Extended Appeals

When notification of a SEND tribunal case comes through to the provider's nominated inbox, a report must be submitted prior to the deadline stated. This deadline may vary between cases dependent on the requirements of the Tribunal judge. The local authority will decide who needs to attend the Tribunal dependent on the needs of each case. It is the duty of the provider to offer support and appropriate guidance and training to all staff who may be reasonably expected to attend a Tribunal.

If during a Tribunal the judge directs for an assessment to take place from one of the disciplines within CCYPS and the child or young person isn't known to the service, the provider will carry out this assessment, or will explain why the child or young person does not meet the criteria for the service.

Clinicians/therapists and/or appropriate manager will prepare reports and attend SEND tribunals as per statutory legal process and when needed for children/young people who have or are receiving care from the service. This is particularly in relation to Extended Appeals, it is expected that the report will include expert advice ; clinicians/therapists must respond to any request for information and evidence within the timeframe set by the Tribunal. In addition, if required, a representative from the respective clinical service must attend the hearing and give oral evidence.

Location of service delivery

Services will be locality based and the provider will ensure strong links with general practice in order to support appropriate use of GP services to avoid unnecessary paediatrician and ED attendances and hospital admissions and to support the development of seamless transition to adult services.

In Nottingham City Place Based Partnership, the locality-based hubs will integrate with the Primary Care Network model through which primary care services, community health services and social care services for adults are working to support the needs of Nottingham City patients.

Interventions will be delivered in a variety of locations and at times to meet the needs and choice of children, young people and families. The provider will use the Department of Health's "You're Welcome" quality criteria for young people friendly services as guiding principles to be accessible in age appropriate, child and young person friendly locations. Locations will include but are not limited to:

- Client's home
- Health centres
- Community clinics
- Education settings such as schools, colleges and nurseries
- Early years settings such as sure start and children's centres, playgroups
- Children's development centres

- Private day nurseries
- Short break settings
- Other sites as applicable

Where an intervention is largely delivered within school in term-time (including elements delivered by trained education staff) equivalent provision will be delivered during school holidays or during periods of absence such as illness in order to meet identified health needs.

Response time and days/hours of operation

The service will respond to the needs of children and young people and will deliver services appropriately in order to deliver the outcomes.

Responses times are as outlined above.

The service will deliver:

- Routine late afternoon/evening and weekend provision.
- Rapid response will be flexible wherever appropriate to meet individual needs
- End of life support available 24 hours a day, 7 days a week, 365 days a year.

The service provider must ensure that other activity delivered by the provider (i.e. commissioned by other organisations/agencies) does not have a negative impact on capacity to deliver the service commissioned under this specification.

G) Review

Review will be undertaken as appropriate to ensure that care provision for children and young people continues to meet their needs, including consideration of eligibility for Education, Health and Care plans and continuing health care.

H) Transition to adulthood and/or adult services

Proactive planning and care pathways will be developed in line with local and regional (Everybody's Business: East Midlands Best Practice Guidance for Young People Moving on from Children's Services November 2014 developed by the East Midlands Clinical Networks) transition guidance and the Together for Short Lives transition care pathway (http://www.togetherforshortlives.org.uk/professionals/care_provision/care_pathways/transition_care_pathway) which provides a generic framework for local adaption specifically for teenagers and young adults with life-threatening, life-limiting or complex medical conditions.

A transition plan will be developed for all children and young people from age 14 years. This will contain concise, consistent and clear documentation with all relevant information about the young person's transition for all those involved in the transition process.

Development of transition planning and processes will include the following:

- Workforce development to meet the needs of young people during transition
- Use of the Nottinghamshire CCYPS Programme Families' Statement of Expectations (see appendix 1) as guiding principles
- Support for the continuation of the personalisation approaches and systems used by the young person following transition to adulthood
- Statutory duty to contribute to and provide services to young people/adults within Education Health and care Plans (EHCP) in line with the Special Educational Needs and Disability (SEND) legislation https://www.gov.uk/government/publications/send-managing-changes-to-legislation-from-september-2014
- Reference to the recommendations within the Nottinghamshire Joint Strategic Needs Assessment Children's Chapter – Transitions http://jsna.nottinghamcity.gov.uk/insight/Strategic-Framework/Nottinghamshire-JSNA.aspx

The service will work in partnership with children's and adult's commissioners, adult community health and social care services, GPs and related services involved in the care of young people with additional health needs including disability and complex needs and those requiring palliative and end of life care to ensure seamless continuity of care during transition from children's to adults services.

Where a young person is at the end of life and would be expected to transition to adult services the CCYPS provider will continue to deliver a service, as appropriate, to ensure continuity of care and support close to the end of the young person's life.

I) Discharge

Where a child or young person's care is complete, transition out of the service will be made in line with appropriate guidance. Clear reasons for discharge will be discussed and communicated with the child or young person and their parents/carers, and information shared with the GP, the referrer and other appropriate professionals such as universal health services, community

paediatricians and social care services. Processes/pathways will be in place to enable fast track access to the CCYPS service should needs re-occur.

3.2.5 Information and Advice Services

The provider will ensure delivery of coordinated information and advice services, which may include co-location and shared branding with local authorities information and advice services, delivered in line with best practice and the requirements of SEND legislation.

Information, advice and resources will be provided to children and young people with physical or learning disabilities and/or complex health needs and their parents/carers, professionals and circle of support. Strong links with acute and community health services will facilitate this. This will include the delivery of 'information prescriptions' requested by paediatricians. Information and advice will be readily available in venues, times and formats to best meet the needs of children, young people and parents/carers (e.g. available in a range of languages and formats suitable for the diverse population groups accessing the service) including on-line and face-to-face. The service will be widely promoted.

Information about and promotion of the CCYPS service will be proactively shared and marketed in a wide range of settings including, but not limited to, disability hubs, schools, the local offer, and 111 services.

3.2.6 Information Management and Technology

Information management and technology (IMT) systems will support the principle that core information about children and young people will be recorded once and shared appropriately, supported by relevant levels of consent and choice, delivered in line with information governance policy and the safeguarding board guidelines. This will include but is not limited to:

- Shared or integrated electronic care records with access for all appropriate professionals including GPs.
- Access to a shared care plan for the child or young person and their parents/carers, which is centred around their needs and enables them to communicate information with the service.
- Mobile access with appropriate security and information management safeguards.
- Use of appropriate assistive technology to offer support and flexibility in the care delivered.
- Innovative use of technology to support improved contact and support e.g. teleconsultation.
- Compliance with relevant Information Governance, confidentiality and consent standards.

Further IMT requirements are detailed in Appendix 5.

3.2.7 Workforce

The workforce must have sufficient capacity, skills knowledge and behaviours in order to effectively deliver the service to meets the needs of the local population and achieve the outcomes identified. The provider will have a clear workforce development plan covering the whole workforce to demonstrate how the following will be achieved:

- Discipline specific professionals with specialist levels of skill to undertake assessment, care planning, interventions and management/supervision of multi-skilled colleagues
- Multi-skilled professionals and support workers/skilled carers, to support delivery of multi disciplinary interventions
- Administration and data management support
- Staff with specialist communication skills
- Staff with skills in peer support, key working, care co-ordination or advocacy
- Staff with appropriate skills in medicines management/prescribing, nutrition support and phlebotomy.

Development of the workforce will respond to the opportunities to develop new roles across traditional boundaries, recognising skills and competencies which require a specific professional registration and those which could be shared and developed across professional boundaries.

The provider will ensure that the workforce have the equipment and supplies to undertake their roles.

The provider will be actively engaged with the Local Education and Training Council (LETC) to ensure workforce risks and priorities have been identified and good practice in relation to workforce is shared accordingly.

3.3 Population Covered

The Community Children and Young People's Service (CCYPS) will be delivered for children and young people registered with GPs in the Nottingham and Nottinghamshire Integrated Care System, namely:

- Mid Nottinghamshire Place Based Partnership (excluding paediatric phlebotomy)
- South Nottinghamshire Place Based Partnership
- Nottingham City Place Based Partnership

3.4 Any acceptance and exclusion criteria and thresholds

Any child or young person aged 0-18 years (or 19 years if in full time education) with a clinically indicated need for the service will be accepted by the service:

- **SUB SPECIFICATION E: Children and young people's community phlebotomy provision**

- All children and young people aged 1-12 years AND children and young people with additional needs 1-18 (19 in education) registered with a GP in South Nottinghamshire (Rushcliffe, Nottingham North and East, Nottingham West) and Nottingham City Place Based Partnerships.

- **Young people aged 19-25 will be supported for the following:**
  - Respiratory physiotherapy with rapid response.
  - Areas of CCYPS provision on a case-by-case basis for young people with an EHCP where there is no adult provision to transition to.
  - Young people over the age of 25 that have previously been supported by the respiratory physiotherapy with rapid response service will be retained and will continue to be supported by the provider. New patients over the age of 25 will not be accepted.

- **SUB SPECIFICATION C: Speech Language and Communication Needs (SLCN) service for preschool children**
- Home Talk for 2-2.5-year olds
  - At 2 years: Children who have 0 to 30 words and have no social interaction or comprehension problems. 2 – 2 ½ year review
- Closer to 2½ years: Children who:
  - have no social interaction or comprehension problems
  - are not using a wide range of single words (less than 50)
  - are only using single words and learnt phrase. A learnt phrase is one which the child may have learnt as if it is one word e.g.," thank you", "night night"
- Closer to 3 years: Children who:
  - missed their 2-2.5 review and are found to have a language need identified by partners including early years settings, the Children's Centre Service, and Healthy Family Teams where the child does not meet the threshold for an immediate referral to the SSLT. This cohort will exclude who have already been referred for specialist SLCN support by other SSLT/SFSS/HT or relevant CC services.
  - Children aged 2.5 years who live in the defined area and did not achieve expected level in any ASQ area at 2-2.5 years and have not been referred onto other SSLT/SFSS/HT or relevant CC services.
- The service is not expected to deliver SLCN's interventions to:
  - Children with complex needs and / or presenting with a clear indication of ASD.
  - Children with significant understanding difficulties such as not understanding single words or basic instructions at home.
  - Children with other SLCN such as stammering which require specialist Speech and Language Therapy.
  a. Children over the age of 3.

The service will support children and young people with, but not limited to, physical health needs, learning disabilities, neuro-developmental conditions and emotional and mental health needs where there is a clinical need for this service.

Training will be provided to appropriate community staff and parents/carers supporting a child or young person registered with a GP within the boundaries of South Nottinghamshire (Rushcliffe, Nottingham North and East and Nottingham West) Place Based Partnership and Nottingham City Place Based Partnership. This excludes Bassetlaw ICB except where the child/young person is accessing short breaks from Nottinghamshire County Council where the child/young person would be accessing as 'out of area'.

If a child has school-based needs and attends a Nottinghamshire school but lives out of area, the local service will deliver the support in school but the local ICB where the child lives will cater for their broader care. The provider is to have a case by case conversation with other provider parties to ensure that this is agreed and operationalised. Any issues with this should be escalated to commissioners.

Where the provider supports children and young people from out of area the provider will ensure this does not impact upon the capacity of the commissioned service and re-charge the responsible commissioner/s for this provision. An annual report for CCYPS commissioners will be provided.

3.5 Interdependence with other Services / Providers

A number of partnership working opportunities are presented within the local health and social care community to enhance outcomes for children, young people and families

Integration across health and social care is high on both the national agenda (through the Children and Families Act 2014 and the Care Act 2014) and on the local Nottinghamshire agenda through the Children's Trust Board and Mid-Notts and South Notts Transformation programmes. The provider will be required to work in partnership with health, education and social care commissioners and providers towards greater integration. This may include working towards the integration or alignment of pathways, assessment, care planning and review processes, and/or co-location of services.

The service will liaise and work collaboratively with other agencies and services involved in the care of children and young people, including but not limited to:

111 emergency and urgent care services	Looked after children services

Acute Emergency Departments: (Nottingham University Hospitals NHS Trust and Sherwood Forest Hospitals NHS Foundation Trust)	Maternity services
Acute sector	Nottinghamshire and Nottingham City Local Offers
Adults services (transition)	Optometry and hearing services
Bereavement services	Paediatric and neonatal intensive care units
Child and adolescent mental health services and professionals (including IMHA and IMCA)	Paediatricians in acute care settings
Children and adults continuing care services	Parent/carer/family
Children's Development Centres	Personal budgets and direct payments
Childrens occupation therapy services	Primary Care Out of Hours services (NEMS and CNCS)
Clinical support to appropriate panels and forums (e.g. communication aids panel)	Safeguarding and Multi Agency Safeguarding Hub (MASH)
Community paediatricians	School nursing/public health nursing services
Condition specific Clinical Nurse Specialists	Schools – teachers, teaching assistants
Dental services	Services for speech, language and communication needs
Early support pathways/programmes/targeted support	Short breaks services
Family Nurse Partnership	Social care and Disabled Childrens team
General Practitioners	Special education needs services (include key working services)
Health visiting services	Sure Start Children's Centres and Early Years services
Hospices	Third sector providers
Information, advice and support services	Transport services for children and young people with additional needs and disability
Interpreting services	

3.5.1 Sale of Additional Provision

The provider will ensure that there is capacity and flexibility to enable Nottingham and Nottinghamshire ICB and wider commissioners e.g. schools, Local Authorities, parents/carers/young people (via personal health budgets), to purchase additional provision outside of that which is described within this specification e.g. children's continuing care packages, response to tribunal recommendations.

The provider will ensure that there is capacity and flexibility to enable continuity of care from 1st April 2016, for children and the provider will be expected to fully participate in any review, improvement and development during the life of the contract to ensure that continuing care provision best meets the needs of children, young people and their families.

4. Applicable Service Standards

4.1 Applicable National Standards (eg. NICE)

National standards, policy and drivers applicable to the CCYPS service include but are not limited to:

- Children and Families Act 2014 http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted
- NHS Mandate 2014-15 https://www.gov.uk/government/uploads/system/uploads/attachment data/file/256406/Mandate 14 15.pdf
- Health and Social Care Act 2012 http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
- The Care Act 2014 http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
- Special Educational Needs (SEN) Code of Practice: for 0 to 25 years Statutory guidance for organisations who work with and support children and young people with SEN June 2014 https://www.gov.uk/government/uploads/system/uploads/attachment data/file/325875/SEND-Code of Practice-June2014.pdf
- The Health and Social Care (Safety and Quality) Act 2015 http://www.legislation.gov.uk/ukpga/2015/28/pdfs/ukpga 20150028 en.pdf
- DH (2010) Achieving equity and excellence for children http://www.dh.gov.uk/prod consum dh/groups/dh digitalassets/@dh/@en/@ps/documents/digitala sset/dh 119490.pdf
- DH (2010) National Framework for Children and Young People's Continuing Care http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH 114784
- NHS at Home: Community Children's Nursing Services DH March 2011 https://www.gov.uk/government/uploads/system/uploads/attachment data/file/215708/dh 124900.p df

- Framework 15 - Health Education England Strategic Framework 2014-2029 http://hee.nhs.uk/wp-content/uploads/sites/321/2014/06/HEE StrategicFramework15 final.pdf
- Together for Short Lives transition care pathway
http://www.togetherforshortlives.org.uk/professionals/care provision/care pathways/transition care pathway
- Care Certificate and standards (2015) http://www.skillsforcare.org.uk/Standards/Care-Certificate/Care-Certificate.aspx
- HM Government (2013) Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children http://media.education.gov.uk/assets/files/pdf/w/working%20together.pdf
- Code of Practice for Disability Equipment, Wheelchair and Seating Services - A Quality Framework for Procurement and Provision of Services (2015)
http://www.troubador.co.uk/book info.asp?bookid=3270
- CQC (2010) Essential standards of quality and safety
http://www.cqc.org.uk/sites/default/files/media/documents/gac - dec 2011 update.pdf
- Legislation.gov.uk (2010) Equality Act 2010 http://www.legislation.gov.uk/ukpga/2010/15/contents
- Department for Education (2009) Common assessment Framework for Children and Young People, guidance. http://www.education.gov.uk/childrenandyoungpeople/strategy/integratedworking/caf/a0068957/the-caf-process
- DH (2009) Reference guide to consent for examination or treatment *Second edition*
http://www.dh.gov.uk/prod_consum dh/groups/dh digitalassets/documents/digitalasset/dh 103653. pdf
- DH (2007) Mental Health Act http://www.legislation.gov.uk/ukpga/2007/12/contents
- HM Government (2004) The Children Act 2004 http://www.legislation.gov.uk/ukpga/2004/31/contents
- Multi-agency working (2012)
http://www.education.gov.uk/childrenandyoungpeople/strategy/integratedworking/a0069013/multi-agency-working
- 'You're Welcome': quality criteria for young people friendly health services
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH 126813
- DH (2001) Seeking consent: working with children
http://www.health.wa.gov.au/mhareview/resources/documents/UK DoH Consent children.pdf
- Children and Young People's Outcomes Forum Pledge for better outcomes https://www.gov.uk/government/uploads/system/uploads/attachment data/file/207391/better health outcomes children young people pledge.pdf
- Children and Young People's Health Outcome Forum 2014
https://www.gov.uk/government/publications/responses-from-children-and-young-peoples-health-outcomes-forum
- Coventry and Warwickshire's Children and Young People's Teaching and Assessment Framework http://covandwarkschildcomps.org.uk/
- Children and Young People's Health Services Data Set http://www.hscic.gov.uk/maternityandchildren/CYPHS

Clinical practice and interventions will be delivered in line with relevant evidence based pathways, guidance, standards and resources e.g. as published by the National Institute of Health and Care Excellence (NICE) https://www.nice.org.uk/ and Together for Short Lives http://www.togetherforshortlives.org.uk/professionals and/or relevant locally developed resources derived from these.

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

Standards set out in Guidance and/or issued by a competent body include but are not limited to:

- The Health and Care Professions Council Standards of conduct, performance and ethics http://www.hpc-uk.org/aboutregistration/standards/standardsofconductperformanceandethics/
- British Association of Occupational Therapists and College of Occupational Therapists professional standards, codes of conduct and professional guidelines http://www.cot.co.uk/professional-resources
- Royal College of Paediatricians and Child Health http://www.rcpch.ac.uk/
- Chartered Society of Physiotherapy – Quality Assurance Standards (2012) and Code of Professional Standards and Behaviour http://www.csp.org.uk/professional-union/professionalism/csp-expectations-members/quality-assurance-standards
- Chartered Society of Physiotherapy (2007) Information to guide good practice for physiotherapists working with children www.csp.org.uk
- Royal College of Speech and Language Therapist Professional Standards (members only) http://www.rcslt.org/account/login?d=http%3A%2F%2Fwww.rcslt.org%2Fspeech and language therapy%2Fstandards%2Fstandards overview
- DCSF (2008) Bercow Report Review of services for Children and Young People (0-19) with Speech, Language & Communication Needs. (https://www.education.gov.uk/publications/standard/publicationDetail/Page1/D16-7520-0308)
- Royal College of Speech and Language Therapists (RCSLT) Communicating Quality 3 (2006) – clinical guidelines and recommended best practice in service organisation and provision (up-dated regularly via website www.rcslt.org) (http://www.rcslt.org/speech and language therapy/standards/CQ3 pdf)
- RCSLT – Clinical Standards documents (members only section) http://www.rcslt.org/account/login?d=http%3A%2F%2Fwww.rcslt.org%2Fmembers%2Fwelcome%2 Fmembers section

- Supporting children with speech, language and communication needs within integrated children's services Position Paper, Marie Gascoigne, January 2006 http://www.rcslt.org/members/publications/publications2/supporting_children within intergrated ser vices
- Nursing and Midwifery Council Standards of conduct performance and ethics http://www.nmc-uk.org/Publications/Standards/The-code/Introduction/
- Royal College of Nursing Best Practice Guidance – Delegated Tasks List (RCN, 2008 – Appendix three)
- The BNF for Children (England/Wales/Scotland) at www.bnfc.org
- Medicines Standard: National Service Framework for Children, Young People and Maternity Services at www.dh.gov.uk under Policy and Guidance, Health and Social Care Topics, Children Services
- Royal College of Paediatrics and Child Health – guidance and standards www.rcpch.ac.uk/publications
- Department of Health – Every Child Matters 2003 https://www.education.gov.uk/consultations/downloadabledocs/everychildmatters.pdf

4.3 Applicable local standards, policy and drivers

Local standards, policy and drivers applicable to the CCYPS service include but are not limited to:

- Joint Nottinghamshire Integrated Community Children and Young People's Healthcare Programme, phase 1 report and recommendations. September 2013 - key driver for the CCYPS service http://www.nottinghamcity.nhs.uk/images/stories/docs/About us/Publications/Strategy planning/IC_CYPHP FINAL.pdf
- Better Together: the Transformation Programme for services across Mid-Nottinghamshire https://em.hee.nhs.uk/workforce/better-together-the-transformation-programme-for-services-across-mid-nottinghamshire/
- South Nottinghamshire Transformation Programme five yeart strategy http://www.nottinghamwestICB.nhs.uk/index.php/south-nottinghamshire-transformation-programme-five-year-strategy
- Nottinghamshire County Joint Strategic Needs Assessment for Children and Young People 2014 http://jsna.nottinghamcity.gov.uk/insight/Strategic-Framework/Nottinghamshire-JSNA.aspx
- Nottingham City Joint Strategic Needs Assessment for Children and Young People with Learning Difficulty and Disabilities (2014) http://www.nottinghaminsight.org.uk/insight/jsna/jsna-home.aspx
- The Nottingham Children's Partnership Early Support Pathway (2011) (www.nottinghamcity.gov.uk/CHttpHandler.ashx?id=31625&p=0)
- Nottinghamshire County Pathway to Provision (2014) http://www.nottinghamshire.gov.uk/caring/childrenstrust/pathway-to-provision/
- Nottingham City Council - Nottingham City Early Intervention Programme (http://www.nottinghamcity.gov.uk/index.aspx?articleid=520)
- Nottinghamshire and Nottingham City Safeguarding Children Boards' Safeguarding Children Procedures June 2012 (Re-published September 2012) (http://www.nottinghamcity.gov.uk/CHttpHandler.ashx?id=36355&p=0)
- Nottingham and Nottinghamshire Safeguarding Adults Procedures and Practice Guidance http://www.nottinghamshire.gov.uk/caring/protecting-and-safeguarding/nscb/informationprofessionals/procedures-practice-guidance
- Nottinghamshire County Health and Wellbeing Strategy 2014 – 2017 http://www.nottinghamshire.gov.uk/caring/yourhealth/developing-health-services/health-and-wellbeing-board/strategy/
- Nottingham City Health and Wellbeing Strategy (2013 - 2016) – draft http://www.nottinghamcity.gov.uk/onenottingham/CHttpHandler.ashx?id=41483&p=0
- Nottinghamshire Children and Families Plan 2014 -2016 http://www.nottinghamshire.gov.uk/caring/childrenstrust/childrenyoungpeopleandfamiliesplan2014to 2016
- Integrated Commissioning Group SEND Joint Commissioning Strategy http://www.nottinghamshire.gov.uk/caring/childrenstrust/developmentwork/disabilitysenintegratedcommissioning

SUB SPECIFICATIONS OF THE COMMUNITY CHILDREN AND YOUNG PEOPLE'S SERVICE

The following clinical discipline specific elements or 'sub-specifications' embedded within the ICYPH service will be delivered as coordinated service so that children, young people and their families experience seamless provision and have their health needs met wherever they are.

Please note: The sub-specifications are not stand alone specifications. They form part of and should be read and used in conjunction with the CCYPS specification above and accompanying appendices below.

Sub-specifications:

D – Children and young people's community nursing

SUB SPECIFICATION D: Children and Young People's Community Nursing

Please note: *This is not a standalone specification. It forms part of and should be read and used in conjunction with the CCYPS service specification above and accompanying appendices below.*

Purpose

"NHS at home: Community Children's Nursing Services" (DH March 2011) summarises the contribution community children's nursing services, as a key component of community children's services, can make to improving the outcomes for children, young people and their families. The guidance separates the needs of ill and disabled children and young people into four groups:

- Children with acute and short-term conditions (requiring interventions over and above those provided by universal and primary care services, to avoid hospital admission and/or reduce length of stay)
- Children with long-term conditions (this excludes the activity delivered by condition specific Clinical Nurse Specialists based within Acute Trusts)
- Children with disabilities and complex conditions, including those with continuing care packages in need of additional support from CCYPS
- Children with life-limiting and life-threatening illnesses and conditions, including those requiring palliative and end of life care

The children and young people's community nursing element of CCYPS service will provide high quality, responsive community-based nursing care, which includes holistic health needs assessments with the implementation of individual nursing care plans for children and young people with acute and additional health needs including disability and complex needs and those requiring palliative and end of life care.

In addition to those listed in the Scope, see 3.1, the objectives are to:

- Provide responsive nursing care and support when children and young people have community nursing needs wherever they may reasonably be expected to be.
- Support children and young people to achieve optimum health, reduce the impact of their illness and/or condition on their health and wellbeing and enhance quality of life.
- Support children and young people at the end of life (and their families) to have a positive experience wherever possible, including choice of place of care.
- Offer multi-agency support in order to enable others to provide care to this cohort of service users. This includes providing support to schools to develop care plans that will enable schools to ensure children and young people gain optimal benefit from the educational setting. This support should be led by the most appropriate professional within the service. This is in line with requirements from the Department for Education (2015) Supporting pupils with medical conditions in schools.

Categories of need

The provider will support children and young people with nursing needs that cannot be met by universal services and can be safely managed in the community.

Some examples of interventions and nursing support to be delivered by the service include, but are in no way limited to:

- Administration of medication (including intravenous medication, enteral medication and emergency medication)
- Administration of chemotherapy and taking oncology bloods, in partnership/liaison with the Paediatric Oncology Outreach Nurses (POONs)
- Central venous lines, portacath care including taking of bloods
- Wound care
- Enteral management and support (including re-siting of gastrostomy tubes/peg and nasogastric tubes)
- Eliminating, including continence support: working in partnership with the 0-19 Healthy Families Programme to provide tier one continence support for any child with a continence need over and above the universal service offer (including enuresis)
- Respiratory and tracheostomy care
- Home oxygen therapy and ventilation care
- Oral suction/nasal suction

- Newborn blood spot for babies who move into area

The service will use the Together for Short Lives 'A Core Care Pathway for Children/young people with Life-threatening and Life-limiting Conditions Framework' to support delivery using guidance from the Children's Act (2004).

Workforce:

Children's community nursing will be delivered by a team of nurses from a broad skills and knowledge base to meet a broad spectrum of needs and degrees of complexity/specialism. This will include an appropriate skill-mix of paediatric nurses and other NMC registered nurses supported by multi-skilled nursing associates, support workers and healthcare assistants.

Nursing care in the community, including schools

The provider will deliver high quality evidence-based care to:

- Undertake holistic health needs assessment with the implementation of individualised nursing care plans for children and young people with additional health needs.
- Provide timely assessment, treatment and nursing intervention, with an aim of providing care in the community; at home or in school (including all special schools).
- Provide ongoing clinical monitoring of children/young people who have an unstable medical condition, illness and/or a life limiting or life-threatening condition.
- Provide holistic, ongoing support from point of referral until discharge is appropriate, with a coordinated MDT approach.
- Provide long-term support for all children and young people known to the service with long-term conditions on a regular basis.
- Work in partnership with other agencies to provide services which address the child or young person's health, acute, social, educational and emotional needs throughout the period of their illness.
- Provide assessment and intensive nursing support and interventions to children and young people in community settings, including their home, for children and young people with acute episodes to avoid admission to hospital services where clinically safe and appropriate.
- Deliver prevention and earlier interventions for children and young people with needs that cannot be met by universal services in order to reduce risks, improve future health and well-being and/or prevent deterioration in health conditions
- Work in partnership with universal services to follow up repeat attendances and discharges from acute services and deliver appropriate intervention and support.
- Mechanisms will be in place to enable referrals to be triaged 7 days a week, 365 days a year in order to facilitate safe timely discharge from the acute setting and/or support avoidance of acute admission/attendance.

Palliative and End of Life Care

The service will provide palliative and end of life care to children and young people who are 0 - 18.
A multi-disciplinary team will provide high quality evidence-based care:

- To ensure that there is multidisciplinary person-centred working, and that the teams work in partnership with continuing care and other services who come into contact with the child.
- To consider implementing a package of care around the family prior to and following the death of the child or young person.
- To offer immediate bereavement support services.
- To sign post families to bereavement support services where appropriate.
- To ensure that there is parallel planning with continuing care providers for alternative outcomes whilst providing palliative and end of life care and support.
- To ensure that there is good communication and parallel planning with other community nursing services within the Trust for alternative outcomes whilst providing palliative and end of life care support.

APPENDIX 1: Families Statement of Expectations

CCYPS Programme Families Statement of Expectations

Our values are...

- Respect
- Collaboration
- Continual improvement

1. "No decision about me without me".

We are consulted and listened to, heard and treated with respect as experts on our/our own child's condition and have our views taken into account at all times.

2. Access to information and supplies.

We can easily get information, advice and guidance, and the services and supplies that we need, when we need them, so that our family can enjoy the best possible health and fulfilling lives. This should enable and support our roles, lifestyle choices and aspirations.

3. Whole systems working.

There is collaborative, joined up and timely planning and service delivery, with all parts working as a whole across all organisations and agencies involved in every aspect of our children's care.

4. Child/young person centred care.

Every child/young person is treated as an individual.

5. Communication and record sharing.

There is timely communication and shared documentation including core essential information about our children, their condition and their support between all those who need to be involved.

6. Capacity, competency and empathy.

We are confident that there are enough staff, who have the right knowledge, skills and expertise for what they are there to do, and they demonstrate this by empathy and understanding in all contacts.

7. Transition.

Children/young people are supported to achieve responsibility for themselves as adults and the family is supported during this period of transition to adulthood and reduced dependence on the family.

8. Continual improvement.

We can see that everyone involved in our children's care is committed to continually improving what they do.

9. Care environment.

Children/young people are seen in age appropriate environments furnished and equipped to meet their needs, taking into account chronological and developmental age.

10. Safety.*

At all times our children are protected from harm.

*Please note this is wider than safeguarding - consider points such as moving and handling training for parents, safe use of equipment etc.

APPENDIX 2: Phase 1 Recommendations

The Joint Nottinghamshire CCYPS Programme Phase 1 Recommendations are:
1. The 'Families' statement of expectations' should be used as guiding principles in the design, commissioning and provision of services and to develop standards to measure service user experience against.
2. Involve parents and young people in the development phase and prototyping of proposed integration.
3. Promote 'Contact a Family' resources for general practice and encourage GP practices to complete the self assessment in order to identify key areas of focus. This will support GPs to enable families with children and young people with disabilities to access GP services and to reduce hospital admissions.
4. Develop education and training opportunities for GPs and practices.
5. Identify GP champions to raise the profile of the CCYPS programme in phase 2.
6. Develop a Practice Specific Objectives Target for 2014/15 (Nottingham City ICB) to update patient registers with specific categories (e.g. carers) and define some parameters of care which would help GPs to support children and young people with additional health needs and their families.
7. Develop and implement a mobile working system for children's community services.
8. Continue to monitor data to identify any further areas of work to focus on, in particular analysis of workforce data to assess competencies and skill mix to inform a workforce development plan.
9. Develop meaningful quality and outcome measures as key performance indicators, which can be reported without creating burdensome and unnecessary bureaucracy for providers or commissioners. This should include standard, comparable measures relevant to all services to facilitate ease of reporting and consistency and to enable benchmarking as well as key outcome measures appropriate to individual services.
10. Adopt/adapt the Family Friendly Framework (FFF) in phase 2 of the CCYPS programme to support the development of a coordinated network model of children's community health services and pathways designed around the needs of children, young people and families, to reduce duplication, achieve seamless flow between services and good experience and outcomes.
11. Prototype shared records, assessments and care plans in children's community nursing services.
12. Align the CCYPS programme with the SEND legislation development work in Nottingham City and Nottinghamshire County in phase 2.
13. Develop ICT functionality and compatibility across organisations.
14. Invest in increased use of assistive technology to address the individual needs of children and young people as part of the development of coordinated services and support.
15. In developing a single point of access and multi-agency, multi-disciplinary hub ensure that the challenges and considerations identified in phase 1 are included.
16. Develop key working for families with children with additional needs in collaboration with SEND legislation development work in Nottingham City and Nottinghamshire County in phase 2.
17. Ensure that proactive transition pathways, planning and support, including personal health budgets, for all children with additional needs are included in the new service network.
18. Build mental health prevention, recognition and early support and access to mental health services for any member of the family into a coordinated model and service specifications, which considers the mental health needs of the whole family.
19. Embed the principles of good safeguarding and early intervention to meet the 'children's request for protection' ('Working to gether to safeguard children') within the design, development, specification and delivery of coorindated services.
20. Ensure all work of the Mid-Nottinghamshire NHS Integrated Care Transformation Programme (ICTP) and CCYPS Programme is aligned in phase 2 of the programme (County only).

APPENDIX 3: Coordinated model of children's service delivery

The essential interdependent elements of a coordinated model of children and young people's community health care delivery.

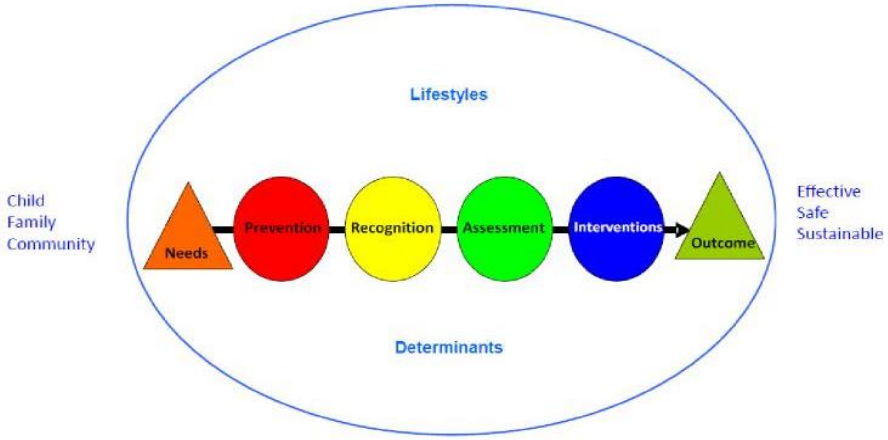
APPENDIX 4: Pathway and Network Definitions

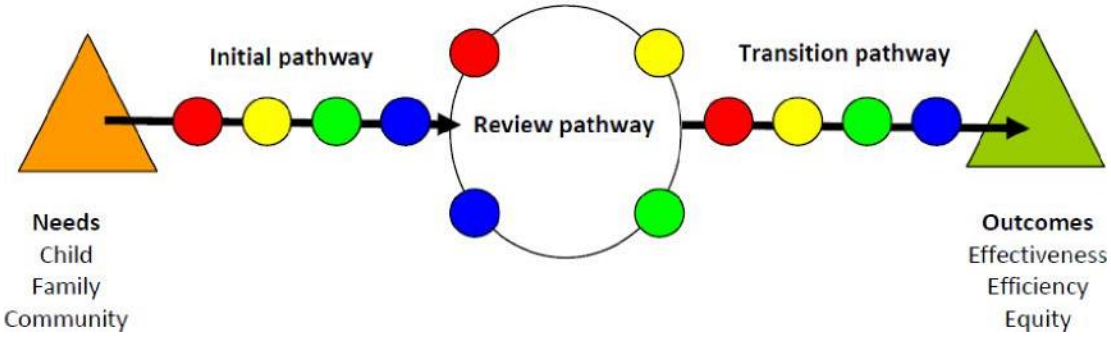
A **pathway** is a description of the best management of a concern/condition. For a short term condition it links four component parts: prevention, recognition, assessment and interventions. For a long-term condition these component parts are replicated into a programme of care consisting of the initial pathway (up to diagnosis and treatment), a review pathway (living with the condition) and transition pathway (back to normal, onto adult services or into end of life care/services) illustrated in Figure 2.

A **network** comprises all the teams that deliver component parts of the pathway and are involved with the management of a group of conditions which collectively strive for continuous improvement.

Pathway components:

Illustration of the FFF long-term pathway with 3 phases – the initial, review and transition phases, each with four component parts. (Source http://www.bacch.org.uk/policy/BACCH%20Improving%20commissioning%20practice%20v17.2.pdf)





APPENDIX 5: Information Management and Technology (IMT) Requirements

To deliver the CCYPS service it is anticipated that information management and technology (IMT) will be a key enabler. Whilst the specific information system functional requirement will vary across the spectrum of care there are a number of expectations th at will be consistent. Access to a shared or integrated record that allows the care provider/s to gain insight into the whole picture of care will b e essential. Whilst it is important that this should conform to best practice Information Governance policy, including appropriate levels of consent and choice, this should not hinder the ability of care professionals to access all the information they need electronically. It is antici pated that this would be demonstrated through appropriate Data Sharing Contracts and Information Sharing Agreements supported by good policy and advice to care providers to ensure the right balance between choice and an unnecessary burden being placed on the service users and their carers. This will support transition from service to service and avoid unnecessary repetition for families when dealing with multiple services of care.

With more emphasis on supporting self-care and carers the provision of patient access to a shared care record will also improve communication with families and clarity on how care plans are to be delivered. Existing pieces of work to consider and align with in this field include: the Nottinghamshire Childrens Wiki for Education, Health and Care Plans and the NHS England Patient On-line Access to GP Records Projects.

In order to ensure the safest, most effective and efficient service is provided, it is anticipated that care staff will have access to th e necessary information contained in shared or integrated records whilst at the patient side, in the location that fits the patien t's needs. This will require mobile access with appropriate security and information management in order to access and record information in a contiguous and contemporaneous manner (in line with professional records keeping best practice policies).

The National Information Board (NIB) has published its framework for action (2013) with a timeline (available at https://www.gov.uk/government/publications/personalised-health-and-care-2020/using-data-and-technology-to-transform-outcomes-for-patients-and-citizens) for clinicians across primary, urgent and emergency care to be working without the need for paper records by 2018. By 2020, it is anticipated that all care records to be digital, real-time and interoperable and by April 2020, the entire health system will adopt SNOMED (Systematised Nomenclature of Medicine) clinical terminology. To support the delivery of these actions locally the provider/s of the CCYPS service will be expected to participate in the Connected Nottinghamshire Programme – a programme of work facilitating information systems interoperability (across Health and Social Care) to support service transformation across Nottinghamshire.

With emphasis on keeping the children and young people out of hospital and avoiding unnecessary hospital visits it is anticip ated that appropriate Assistive Technology will offer support and flexibility in the care delivered. Where appropriate, services users and their carers should have the ability to record and share information relating to the on-going management of their condition(s) with care professionals. The innovative use of technology to support improved contact and support through Teleconsultation is an emerging area and should be considered.

The CCYPS Provider will be expected to implement systems to collect and report on the national Children and Young People's He alth Services Data Set: http://www.hscic.gov.uk/maternityandchildren/CYPHS

Key Systems:

The current systems architecture across Nottinghamshire comprises of the systems listed in the table below:

Organisation	Primary Care	EMAS	CityCare	NHFT	NUH	SFH
Existing systems supporting integration	TPP SystmOne EMIS Web eHealthscope (locally developed care management and risk stratification tool	Emergency Care Solution (part of CSC suit with HL7 links into TPP and Summary Care Record access), DTS messaging	TPP S1	RIO, TPP S1, Summary Care Record, ICE and implementing a Viper 360 Portal	System C Medway, TPP Clinical Record Viewer , ICE, in-house de portal type product, Summary Care Record and DTS messaging	McKesson Medway, TPP ED,TPP EPR Core, ICE, Orion portal, Summary Care Record, DTS messaging and implementing a portal product

Information Governance Requirements:

All providers will ensure that they meet the necessary assurance levels for the following:

1. PSN COCO

2. NHS COCO
3. IGT level 2
4. DPA
5. Caldicot 2 Principles

APPENDIX 6: Glossary of acronyms, abbreviations and terms used in this specification

BACCH	British Association of Community Child Health
CAF	Common Assessment Framework
CAMHS	Child and Adolescent Mental Health Services
CAS	Clinical Assessment Service
ICB	Clinical Commissioning Group
CCN	Children's Community Nurse/Nursing
CCYPS	Community Children and Young People's Service
Circle of Support	All of those who are formally or informally involved in giving care and support to the child/young person.
CNCS	Central Nottinghamshire Clinical Services
CONI	Care of the next infant
CSC	A global provider of technology enabled business solutions and services
CYP	Children and young people
CYPF	Children, young people and families
DH	Department of Health
DNA	Did Not Attend (appointment)
DPA	Data Protection Act
DTS	Data transfer service
ED	Emergency Department
EHAF	Early Help Assessment Form
EHCP	Education Health and Care Plan
EMIS	Egton Medical Information Systems
EPR	Electronic Patient Record
FFF	Family Friendly Framework
GP	General Practitioner / General Practice
HCPC	Health and Care Professions Council
HL7	Health Level Seven International. A not-for-profit organisation responsible for the production and promotion of the HL7 series of healthcare IT communications standards in UK.
ICELS	Integrated Community Equipment Loan Scheme
IGT	Information Governance Tool
IMCA	Independent Mental Capacity Advocate
IMHA	Independent Mental Health Advocate
IMT	Information management and technology

JSNA	Joint Strategic Needs Assessment
MAMs	Multi Agency Meetings
NEMS	Nottingham Emergency Medical Services
NHS COCO	National Health Service Code of Connection
NIB	National Information Board
OT	Occupational Therapy / Therapist
PHB	Personal Health Budget
POON	Paediatric Oncology Outreach Nurse
PSN COCO	Public Services Network Code of Connection
PT	Physiotherapy Therapy / Therapist
RIO	The name of a mental health clinical system
SENCo	Special Educational Needs Co-ordinator
SEND	Special Educational Needs and Disability
SLCN	Speech, language and communication needs
SLT	Speech and Language Therapy / Therapist
SNOMED	Systematised Nomenclature of Medicine
TPP	TPP is a Clinical software provider
TPP S1	TPP Systm1 – clinical software system
Wiki	Rix Wikis: Are a secure multi-media web based tool which gives children, young people and their parents their very own web site to share important information about their life, care and support needs through pictures, video and documents with those they wish to share it with, including professionals, carers, teachers etc The Rix Wiki has been piloted by Nottinghamshire County Council as a tool for children and young people with Special Educational Needs and Disability. The County Council are now working in collaboration with the University of East London to make the request for a Rix Wiki available via Nottinghamshire's Local Offer web site (www.nottinghamshire.sendlocaloffer.org.uk
YP	Young people/person