SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	S016a
Service	Community Paediatrics
Commissioner Lead	Integrated Children's Commissioning Hub
Provider Lead	NUH
Period	*Added to the NUH Contract May 2018*
Date of Review	*To be reviewed annually*

1. Population Needs

1.1 National/local context and evidence base
The Provider will ensure:

- Provision of a high quality, effective community paediatrics service that implements all relevant good practice guidance by clinical condition and deals with all service users holistically and across multiple agencies as indicated to ensure health and non-health needs are addressed using a whole system approach. For clarity this service specification covers the services previously referred to as :

  a) General Community Paediatric Out Patient Service
  b) Support to Schools / Children's Services Education Divisions (CSED)
  c) Specialist Community Paediatric Life Threatening and Life Shortening Conditions Service
  d) Paediatric Neurodisability and Neurodevelopmental Disorders (excluding those covered by NHS England (NHSE) services).

- Use of models of care which support quality service delivery will be expected.

1.1.1 Local context

As an STP our system has committed to drive change along **six main directions** in order to reach our goals and overcome our challenges:

- Organise care around individuals and populations –not organisations—and deliver the right type of care based on people's needs. e.g.,
  - Help those who are largely well today (most of the population) stay well through prevention and health education to stay well and manage minor issues themselves in so far as it is possible;
  - Help those with a complex or advanced long-term condition that need professional expertise and support to be as enabled as possible to manage their own care, to have an identified system to escalate care quickly in the event of exacerbations, and to have regular monitoring to identify changes in their health and social care needs as early as possible
- Help people remain independent through prevention programmes and offering proactive rather than reactive care, which will also reduce avoidable demand for health and care services
- Support and provide care for people at home and in the community as much as possible – which implies shifting resources into those settings—and ensure that hospital, care home beds, and supported housing are available for people who need them

- Work in multi-disciplinary teams across organisational boundaries to deliver integrated care as simply and effectively as possible
- Minimise inappropriate variations in access, quality, and cost, and deliver care and support as efficiently as possible so that we can maximise the proportion of our budget that we spend on improving health and wellbeing
- Maximise the social value that health and social care can add to our communities

We have identified 3 enablers within the STP, this specification falls into the enabler -"Drive system efficiency and effectiveness" – ensure the health and care system operates as efficiently and effectively as possible in order to reduce waste and reduce unnecessary variation in the way we deliver care.

Our STP has identified that our system needs to transform to meet the needs of the population within the resources we have available and using new methods of transformational care fit for how people live their lives today. There are many traditional patterns of care which can now be delivered through different technologies or care delivered differently.

Care for service users where they go back to hospital to be seen repeatedly is an area where our STP has identified we could be more efficient and effective for service users in terms of the clinical interventions they receive and for clinical services for the best use of the clinicians for service users with the highest level of need.

Commissioners are therefore undertaking a stocktake of current service provision and analysing any areas where a change to delivery is required to ensure all services provide the greatest value, both from a service user outcome perspective and value for money.

1.1.2 Policy Guidance

The Service must be provided in-line with national priorities and the latest guidance and also be cognisant of guidance from other reputable sources such as relevant Professional Bodies.

In Nottinghamshire and Nottingham City (excluding Bassetlaw) our Community Paediatrician led provision:

- *"Sees children as outpatients for a variety of reasons and their patients can include children with long-term disability (eg cerebral palsy, learning disability), children with mental health issues (eg autism and ADHD), children who it is feared are being abused, or children who are being fostered and adopted*. They also take responsibility for advising on the health of communities."* Definition of Community Paediatricians by Royal College of Paediatrics and Child Health (RCPCH)
- Sees children for *"general paediatric short term conditions (those that resolve in a short period of time (generally <6 months) with or without medical interventions)"* who can/should be seen within the community. Definition of General Paediatric conditions by British Association of Community Child Health (BACCH).

These services are appropriately delivered by professionals who could be described as Community Paediatricians, General Paediatricians or Speciality and Associate Specialist (SAS). These professionals may or may not have a specialism but the provision they deliver is on an outpatient basis and should be delivered in a community setting or if appropriate at Nottingham's Children's Development Centre.

*There are separate service specifications for statutory provision.

Facing the Future: Together for Child Health (2015), a joint publication by the RCPCH, RCGP and RCN, sets out the case for national change, moving away from the traditional separate models of care provided by General Practice, Hospital and Community Paediatrics. *Facing the Future* outlines overarching principles which are supported within this specification:

- Every child should have timely access to high-quality unscheduled (for the purposes of this specification this also includes scheduled) care services that are safe, effective and caring,

that promote good health and wellbeing and that reduce the impact of illness on the child and their parents and carers.

- No child should be in hospital when care can be provided to an equivalent or better standard outside the hospital in their locality and closer to their home if appropriate (right care, right time and right place).
- Service providers, planners, commissioners and users should work together across hospital and community services, primary and secondary care and paediatrics and general practice to design and deliver efficient and effective unscheduled care in a geographical network which is responsive to the needs of local children and their parents and carers.

In Nottingham and Nottinghamshire County the following needs have been identified for the population of children and young people with additional needs:

- There are multiple providers/teams working to different processes (e.g. assessments, care plans), policies and procedures and different IT systems resulting in duplication / lack of efficiency and effectiveness (resulting in a negative impact on children, young people and families).
- There are 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.
- Across the landscape, there is a lack of co-ordinated support for children and young people with complex needs and disability and their families.
- 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.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local defined outcomes

The local Outcomes and Quality Framework has been developed to reflect 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 (ICCYPH) Programme. Due to the holistic and wider system nature of the expectations and framework this has been adopted and adapted for the non-statutory community paediatrician led service.

The local service and quality and outcomes framework is underpinned by the domains of NHS outcomes framework and five year ambitions for improving those outcomes, as well as the shared ambitions of the "Better health outcomes for children and young people: Our pledge" 2013 (see

appendix 2).

Each outcome within the Framework will be measured via a number of indicators/outcome measures, which evidences the contribution of this service to their achievement. These draft indicators/outcome measures will be finalised in conjunction with the service.

The provider will work collaboratively with the commissioner in the first two quarters to refine and finalise the reporting requirements for the service within the local outcomes and quality framework. The provider will also respond to data requests from the commissioner to support service redesign and improvement, system configuration work and to meet any other statutory and strategic needs.

3. Scope

3.1 Aims and objectives of service

- To provide all service users who fulfil the referral criteria with a patient-centred service, which optimises their health and well-being, enhances their quality of life and minimises the risk of recurrent events.
- To deliver a responsive service that provides information, advice and support in order to enable service users and their carers to make informed decisions on surgery and other treatment options on an individual basis, including an expectation where available to use validated shared paediatric decision making tools (eg http://sdm.rightcare.nhs.uk/)
- To liaise with other clinical specialties, mental, social and voluntary care services in order to provide a person-centred individual service – for community paediatrics this includes: the ICCYPH (Community Children and Young People's Services); GPs; acute paediatrics; the Healthy Families Service and CAMHS – as part of agreed pathways for integrated child and family care.
- Working to nationally recognised agreed guidelines and standards of care
- To provide a high-quality service which will deliver the key service outcomes.
- To provide a patient-centred service which meets the personal needs of each service user, only requiring service users to attend hospital for a defined clinical reason.
- To ensure that service users and carers have appropriate information allowing them to manage their care more effectively. Offer information, guidance and support to reduce risk factors and encourage compliance with secondary prevention.
- To engage service users and their carers in decisions about the care options available to them, including the expected use of validated shared decision making tools if available (eg http://sdm.rightcare.nhs.uk/), development of individual care plans and long-term management plans and where appropriate cancer survivorship plans, adhering to the principles of the Families' Statement of Expectations (Appendix 1).
- To have quality at its core and be accessible, safe, effective and responsive to service users
- To be evidence-based, clinically led and continually strive to improve outcomes for service users
- To be affordable and represent good value for money
- To deliver an equitable service for service users
- To provide continuity and co-ordination of care across the pathway utilising the system as a whole.
- To ensure that the Service is delivered in a timely manner is evidence-based and delivered by appropriately qualified workforce
- To provide advice, support, input and training to colleagues in general practice, education and local authorities to enable the whole system to better meet the needs of children and young people

Specific objectives for the non statutory community paediatric services are:

- To support early diagnosis and intervention, reducing the personal and societal costs of delayed diagnosis. This includes supporting the Healthy Family Programme and other local and national strategies. The right care will be offered in the right place at the right time.
- Enable children and young people with acute and additional health needs, including

disability and complex needs, and those who have palliative conditions and are at end of life to have their health needs met and pro-actively managed.

- To improve equity and accessibility of services to the most vulnerable and hard to reach children, through a targeted approach to children in the most deprived quintiles of the Nottingham City and Nottinghamshire County populations.
- To work as part of agreed care pathways, across organisation, service and system, providing high quality specialist child and family centred care. This will be delivered by appropriately skilled paediatricians, and may include joint assessments/appointments or co-location of service provision with other services.
- To 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. In particular, this is to minimise duplication, ensure effective use of resources, and optimise the collective benefit to children and young people and their families and informal carers by reducing length of acute stay, facilitating discharge and/or avoiding admission where clinically appropriate.
- To provide advice, support and input to colleagues in general practice, education and local authorities to enable our whole system to best meet the needs of children and young people. Training, apart from specific PLT sessions and safeguarding, can be provided but will incur a charge.
- To deliver a transparent and seamless service that is centred around children, young people and their families, contributing to maximising independence and quality of life (supporting education, leisure and social activities) including pro-active support and planning for transition. Including empowering 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.
- To ensure a sustainable, appropriately trained, supervised and motivated workforce who offer consistent and high quality care.

In meeting the above objectives, the service will support the following visions/plans for children and young people:

Nottinghamshire Children, Young People's and Families Plan 2016-2018 priorities:

- *children and young people are safe in Nottinghamshire*
- *children and young people are happy and healthy in Nottinghamshire*
- *children and young people achieve their potential in Nottinghamshire*
- *children, young people and families receive support when needed in Nottinghamshire.*

Nottingham City Children and Young People's Plan 2016-2020 vision:
A city where every child and young person can enjoy their childhood in a warm and supporting environment, free from poverty and safe from harm; a city where every child grows up to achieve their full potential'

Mid, South and City CCGs' vision for specialist community children and young people's services:
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. 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.

3.2 Service description/care pathway

3.2.1 Service Overview

3.2.1.1 Overview

The community paediatrics service will provide streamlined access and co-ordinated assessment, treatment and review, supported where appropriate by personalised care plans, shared/sharing

records and communication across integrated care pathways so that families experience a seamless service that is centred around the child/young person and family promoting privacy and dignity, independence and quality of life.

Care will 'follow the child/young person' and, where appropriate, 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 be provided within a life-course, multi-disciplinary, multi-agency whole system approach, working with and alongside other services including, but not limited to, acute paediatricians/services, ICCYPH, public health practitioners, midwives, GP's, social care and education, third and independent sector services, including adult services during transition. The service will pro-actively deliver support in line with the Equality Act 2010 and other relevant legal frameworks.

The service will develop pathways in conjunction with commissioners, GPs, hospital based paediatricians, children young people & families and local authorities.

The service pathways will be designed to enhance user experience for children with complex needs this includes enabling access to other members of the multi-disciplinary team at each clinic visit, thus reducing unnecessary appointments.

The service will be delivered in close liaison with hospital based services to avoid admissions where possible, improve care when a child or young person is an inpatient, and to support prompt and safe discharge.

All elements of the delivery of the service must include the provision of all basic diagnostic testing, support from nursing and ancillary staff and administration support required to deliver this service specification.

The Service will ensure that it has access to appropriate interpretation and translation services/resources to enable equity of access and understanding.

Service provision will be underpinned by:

- Effective leadership and a streamlined management structure, including appropriate specialist clinical leadership.
- A culture of continual improvement and innovation.
- Use of 'You're Welcome' standards.
- 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
- Family Friendly Framework (see Appendix 3)

3.2.1.2 Referrals

a) Referral Source

Referrals will be accepted from:-

- General practitioners

- Secondary Care in line with Consultant to Consultant policy (including Neonatologists, paediatric and specialist consultants)

b) Referral Management
There will be a clear single point for receipt of electronic, telephone and (where available) choose and book referrals, with the service promoting use of a single referral template incorporating all relevant information. This will include telephone access to paediatricians to support referrals in each locality. To support the service to keep 'was not brought' (WNB) episodes to a minimum appropriate reminder mechanisms should be in place for appointments (e.g. text messaging reminder service).

All referrals will be acknowledged within 5 working days or 48 hours for urgent referrals (telephone only). This may be achieved by utilising a system such as choose and book.

c) Triage
Senior paediatricians (both community and hospital based) will review, triage and allocate all referrals (or reallocate for referrals made on choose and book); ensuring children are seen in the appropriate clinic, at the right time, and by the right person.

d) "Supported no"
Where children and young people are declined at the point of referral this should be communicated to the referrer within 5 working days of initial referral. The provider will communicate that the referral has been declined in writing to the referrer to support them 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.

3.2.1.3 Care Pathways

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 service will be delivered within a whole system approach based upon the Family Friendly Framework (FFF) developed by the British Association for Community Child Health (BACCH) utilising pathways and networks as units of service delivery. Further detail on the framework can be found in Appendix 4.

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.

This service will provide assessment, diagnosis, and treatment and follow up of children as identified in existing pathways, such as those outlined in the Referral guidelines for paediatric out- patients from primary care, developed by the Nottinghamshire and Nottingham Children's Health network which include the Nottinghamshire Concerning Behaviour Pathway and the Nottingham City Pathway for Behaviour, Emotional and Mental health Needs. These care pathways are not exhaustive and the service will be required to manage the care of all referrals that are deemed appropriate within referral guidelines. Pathways such as the Nottinghamshire Concerning Behaviour Pathway and the Nottingham City Behavioural, Emotional or Mental Health (BEMHs) Pathway are local pathways delivered and agreed in conjunction with education, social care and wider health colleagues and are currently under review.

This includes palliative care and medical support for end of life homecare which are delivered using the local Integrated Multi-agency Care Pathway for Children with Life-threatening and Life-limiting Conditions Framework' (adapted from Act 2004). This includes but is not limited to: care planning for end of life, symptom management, medical assessment, related prescribing needs and on call 24/7 support delivered by the specialist community paediatric service (in conjunction with the hospital paediatricians and the community paediatric nursing service). Support and care at time of death and

appropriate support in bereavement will also be offered by those involved in the child or young person's care.

It also includes the Community Paediatrician led multi-agency 'Early Support and Assessment Service' for neurodisabilities and disorders, other than those covered by NHSE, including; new referral, assessment and learning, integration, planning, support and intervention and review.

Writing, maintaining and distributing Referral guidelines for paediatric out- patients from primary care includes reference to acute paediatrics not included in this specification) will be a core part of delivery under this service specification. The Service will ensure that appropriate and timely primary care referrals are supported. New care pathways and amendments to agreed pathways will be undertaken in conjunction with commissioners, other professionals and the service.

Safeguarding measures will be embedded within the service provision and any formal child protection referral should be made within 24 hours within the agreed local processes (e.g. MASH/Statutory Community Paediatrics provision).

3.2.1.4 Assessment

An appropriate holistic assessment will be undertaken, informed by information gathered at triage. The initial face-to-face assessment will take place within 13 calendar weeks of receipt of referral and will be prioritised based on clinical need. If at referral/triage an urgent assessment is deemed clinically necessary there will be provision, in conjunction with hospital based services, to offer rapid access to clinical assessment by the most appropriate paediatrician (hospital or community).

Assessment will be needs driven and not dependent on receipt of a specific clinical 'diagnosis'. Medical assessment includes but is not limited to investigations in haematology, biochemistry, metabolic, genetic and imaging tests as well as basic diagnostic testing.

Integrated assessment 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 where clinically appropriate to involve clinicians from other services (e.g. for some CYP on Concerning Behaviour/BEMHs pathways/Early Support and Assessment Service).

The views and needs of the child/young person and their parents/carers will be at the heart of assessment. The emotional and mental health of the child or young person, their parents/carers and the wider family will be considered.

All children who require a Care Plan should be given one.

Once assessment is complete the service will use their clinical judgement and results from test/investigation to make diagnostic conclusion with a written record of the outcome shared with the referrer, young person and their family/carer and, where required, other appropriate professionals.

Where appropriate the service will offer telephone support to GPs and families as required outside of scheduled appointments.

3.2.1.5 Input into multi-agency/ professional meetings/ processes

This includes but is not limited to:

a) Early identification

- All children identified by the service as likely to have special educational needs/ additional needs will be notified to the Local Authorities (process to be agreed).
- Make referrals to the Specialist Children's School and Families service (County) or the Early Years Foundation Stage (EYFS) City) where possible and clinically appropriate
- Attend early support meetings or MDT and where required notify the SFSS/PEET
- Input into a multi-agency TAC/CAF meeting
- Input to local pre-school liaison meetings or equivalent

b) Children and young people with palliative and end of life conditions:

- Liaison with partner agencies to promote and enable a coordinated package of support

(community nursing teams, education, early years education teams, social care, voluntary sector)
- Recommending and inputting into children's continuing care assessments
- Multi-disciplinary needs assessment to plan early support and subsequent intervention
- Identification of immediate child and family needs

c) Early support and assessment for Children with mild and moderate neurodisability (excluding those covered by NHSE):
- Provision of a community paediatrician led multi-agency pathway, including medical support for a child's care package including where there is a specific therapeutic input from other interagency teams,
- Liaison with acute hospital based clinicians when children are admitted who have underlying complex disability.
- Acute treatment alongside neurological, neurosurgical treatment, sensory teams e.g. Botulinum toxin, dysphagia assessment, epilepsy care.
- Referral to tertiary specialist neurodisability interventions.

d) Supporting participation in education
- Provide medical advice and liaison to schools around children and young people with medical / additional needs. This may include attending multi-disciplinary 'team around the child' meetings, contribution to Joint Access Team (JAT) team meetings and MAMs (Multi Agency Meetings) or PCRs (City).
- Attend EHC Plan Annual Reviews where possible and clinically appropriate.
- Work alongside Children's Community Nurses, therapists, continuing care staff and school staff to ensure children and young people needs are identified and met in a way that supports their access to, and participation in, education.
- Ensuring that children and young people's health and education outcomes are enhanced through access to high quality, timely and appropriate medical services

e) Education Health and Care Plans (EHCPs)
The service will contribute to the local authorities' EHC processes :
- This will include assessment of needs and contribution to the development of plans and outcomes in relation to a child or young person's needs.
- The provider will work within the agreed statutory timeframes for EHCPs and in line with the Nottingham City or Nottinghamshire County pathways.
- Providing medical input into/attending person centred review (PCR) meetings/MAM, including within special schools, to plan and review the child or young person's health and care needs and package of care. This will be prioritised on the clinical needs of the child or young person with recourse to the wider family situation.
- Co-ordination of health advice for the EHCP process from other clinicians within organisation e.g. hospital paediatricians where needed. This includes liaison and interpretation of medical information

The commitment to the EHCP process is currently under review. The Community Paediatrics service has raised concerns regarding the capacity to respond to the level stipulated within the current process.

f) Other provision as outlined in local/regional/national care pathways or Directory of Services
- For example provision delivered as per the agreed multi-agency Concerning Behaviour and BEMHs pathways (Subject to confirmation and agreement of pathways (and funding if appropriate).

3.2.1.6 **Provision of training, advice and medical input to local partners**
This includes but is not limited to:

a)Designated Medical Officer (DMO)
- The role of the DMO posts within this service specification will be undertaken by consultant community paediatrician/senior SAS. The role of the DMO in Nottinghamshire and

Nottingham City will be to work closely with the Designated Clinical Officer (DCO) for the CCGs providing:

- Clinical advice to support DCO in EHC plan decision making
- Ensuring service provides timely, consistent and high quality information to EHC requests
- Support DCO, where required, with strategic input, promotion of SEND agenda and attendance at Key meetings.
- Provide quality assurance of medical input by supporting DCO in an annual audit of EHC plans.
- Independent medical advice to the local authorities and CCGs when requested including but not limited to tribunals and mediation for EHC plans.

b)Working with Primary Care

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- Attendance at PLT's on priority areas where appropriate within the team's capacity. THIS Training will focus on both clinic based and educational sessions concentrating on the commonest conditions achieving the highest activity levels as well as responding to GPs requests and new developments.

c)Paediatric advice to Primary Care

- GPs will have access to local community paediatric advice, guidance and support (non-urgent). This service will be offered in additional to the Acute Paediatric hotline for acutely ill children (not included in this specification) but where clinically appropriate this service will signpost to the hotline (and vice versa).

d)Strategic partnerships, planning and related work streams

Input as required for the following:

- Appropriate work streams within the Sustainability and Transformation Plan (STP).
- CQC/OFSTED Local Area Inspections for SEND and subsequent SEND Accountability Board programme in Nottinghamshire County.
- Nottingham/Nottinghamshire Children and Young People's Health Networks
- Children and Young People's Mental Health and Wellbeing board executives.
- Concerning Behaviour and BEMHs pathways strategic input.

3.2.1.7 Transfer of care

The service will develop close liaison with hospital/community based provision (including ICCYPH/GPs/Hospital Paediatricians) to avoid admissions where possible, improve care when a child or young person with ongoing Community Paediatric input is an inpatient, and support prompt and safe discharge.

Where children and young people are accessing inpatient services, where appropriate, support will be offered from this service to facilitate timely discharge into the community. In order to support the safe transition of care from hospital to the community, electronic discharge processes will be in place. These must conform to the NHS England core provider contract requirements.

Where a child or young person's care is complete, transition out of the service will be made in line with the Family Friendly Framework. 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 service should needs re-occur.

3.2.1.8 Transitions

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/contributed to, where appropriate, for 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.

The service will work in partnership (including attending meetings where required) with children's and adults' 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/childhood to adulthood.

Development of transition planning and processes will include the following:

- Workforce development to meet the needs of young people during transition (including providing training and support to adult services for procedures and interventions requiring familiarity with an individual patient).
- Use of the Families' Statement of Expectations as guiding principles
- Support for the continuation of the personalisation approaches and systems used by the young person following transition to adulthood e.g. Wiki, "one plan"
- 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 Nottinghamshire County Transitions Protocol

Where a young person is at the end of life and would be expected to transition to adult services the 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.

3.2.1.9 Self Care

Patient, family and carer education is an essential aspect of the service delivery to ensure long-term and sustained improvement. The Service will support parents/carers/school staff in developing their capacity to reduce the health consequences of long term vulnerability in their children. This will include the appropriate provision of written materials and signposting to other support services.

The service will provide children, young people and their families with information on assessment, diagnosis, prognosis and treatment options (as appropriate) alongside signposting to relevant services, provision and information (Local Offer/s).

Signposting between appropriate services and partnership working is an integral aspect of the service delivery. There will be signposting to / consent for referral to other members of the multidisciplinary team within secondary and primary care settings.

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 paramount.

3.2.1.10 Information and advice

Information, advice and resources will be provided to children and young people with physical or learning disabilities and/or complex health needs. This function is currently undertaken by referring

parents/carers, professionals and their circle of support to resources. Strong links with acute and community health services will facilitate this.

Community Paediatricians will support 'information prescriptions' which will be fulfilled by the ICCYPH Information and advice service at the City hospital Children's Development Centre (CDC).

Information about and promotion of the 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.

3.2.2 Service Principles

The service will support the use of the national advice and guidance model within the e-referral system, aligning to locally agreed turnaround times for routine and urgent queries

The service will also support the Nottingham University Hospitals Care Navigator for urgent problems and direct communication between primary and secondary care

On receipt of the initial referral documentation a paper assessment will be made to both ensure the service user is directed to the most appropriate clinic on their first visit, and to consider whether even at this stage a non-face to face solution is applicable eg discussion with the GP or direct to test.

If a face to face consultation is required at this meeting the clinical team should:

Give service users and their carers time to understand the condition, its progression and the ways it can be managed, This should include oral and written information about:

- What the condition is
- Treatments, including disease-modifying therapies
- Symptom management
- How support groups, local services, social services and national charities are organised and how to get in touch with them

If appropriate clinicians may signpost to professionals who can offer information on legal requirements and advice for example; notifying the Driver and Vehicle Licensing Agency (DVLA), and legal rights including social care, employment rights and benefits

On completion of the first contact the health professional will discuss with the service user the clinical reason why any further care is needed. The following options will be discussed taking into account the service user's circumstances and best practice guidance from Right Care/professional bodies/NHS constitutions before determining that further in-hospital care is required:-

- Does the service user need to be seen again, if so has a clear reason been explained to the service user and has their GP been informed? It is expected that follow-ups to solely impart routine results and information results will not be required appointment time may be used to feedback diagnostic results if clinically appropriate.
- Can this be delivered near to the service user's home by a suitable alternative clinician?
- If appropriate clinicians may signpost to professionals who can offer information/ assistive technology
- Does the service user have the capacity to make the decision?
- Are the service user's social circumstances taken account ie, needing to take time off work?

The Provider is expected to adhere to Map of Medicine defined treatment pathways and locally agreed variations

The Provider is expected to adhere to all diagnostic procedure good practice and guidance indicators. For community paediatrics, this includes:

- Use of 'You're Welcome' standards;
- The Families' Statement of Expectations (appendix 1);
- Family Friendly Framework (appendix 3)

The service will apply proactive management approaches to improve the equity and accessibility of the service to promote engagement with the most vulnerable and hard to reach children and young people.

The Service will make provision to address any issues that are within its power to resolve to ensure that it is accessible to all families, children and young people for appropriate targeted support. These include those families from groups such as travellers, asylum seekers, and refugees and those living in areas of high deprivation.

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.

3.2.3 Staffing and Capacity

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 to ensure that a value for money and effective skill-mixed workforce will be in place including:

- Professionals with specialist levels of skill to undertake assessment, care planning, and interventions for the whole range of children and young people's needs. This includes trained doctors who are consultants or equivalent i.e. staff, specialty or associate specialist grade (SAS) doctors, who are trained and assessed as competent in paediatric care. It should also include Paediatric Nurse Specialist, multi-skilled Health Care Assistants and others as appropriate.
- Administration and data management support
- Staff with specialist communication skills
- Staff with appropriate skills in medicines management/prescribing and phlebotomy.

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

The provider will be actively engaged with the appropriate local, regional and national agencies to ensure workforce risks and priorities have been identified and good practice in relation to workforce is shared accordingly. This includes appropriate and timely succession planning.

3.2.4 Professional Competence, Education and Training

- Staff must adhere to all national and local guidelines and policies
- Appropriate training/supervision must be provided to all staff in order to remain competent in practice and staffing levels should reflect this requirement
- Staff must have the appropriate skills, including communication skills to provide accurate, knowledgeable and skilled advice to service users and carers
- Medical staffing rotas must be European Working Time Directive compliant at the levels required for the service.

3.3 Population covered

The service will cover children and their families who are; attending a Nottingham City/Nottinghamshire maintained (special and mainstream) school/further education establishment/early years setting; and those that are registered with General Practitioners from Clinical Commissioning Groups within the NUH consortia as specified within 'The Particulars' of the extant contract.

The service will also cover any other service user as defined in 'Who Pays?: establishing the

responsible commissioner' guidance and other Department of Health guidance relating to service users entitled to NHS care or exempt from charges.

3.4 Any acceptance and exclusion criteria and thresholds

3.4.1 Service Provision

The service will be comply with general standards for paediatric services. Where commissioning responsibility sits with NHSE specialised commissioning this with will be covered by a separate specification.

3.4.1.1 Acceptance criteria

- 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 (unless 18 or over at first appointment –see below). This includes those who remain under the care of acute paediatric consultants but who may also be supported by this service (e.g. those with specific organ failure, oncology and haematology conditions).
- Where a young person is at the end of life and would be expected to transition to adult services the 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.

3.4.2 Exclusion criteria
The service will not offer:

- Episodes of care funded by NHS England, including those provided to children and young people who are receiving care funded through NHS England Paediatric Neurodisability Year of Care tariff.
- First appointments to young people over the age of 18 and clinical judgement will be used for where care is best initiated for young people approaching this age i.e. paediatric or adult provision.
- Any intervention that could be undertaken by a GP. This includes annual medication reviews and prescribing unless they explicitly cannot be undertaken by a GP or other medical professional or where it forms part of a child or young person's wider Community Paediatrician led care (e.g. for those with highly complex/palliative/end of life needs). The service must work towards establishing and supporting shared care, discharge to, or delegation with, appropriate professionals in all applicable areas e.g. Melatonin prescribing.
- The service will not normally be responsible for children and young people on anti-psychotics and anti-depressants medication except in exceptional circumstances where care is delivered in conjunction with other professionals. e.g. Psychiatrists and other CAMHS professionals). Joint working or shared care protocols will be developed in conjunction with commissioners and other professionals.
- Multiple follow up appointments where there is no specialist paediatric support required. The service will work to achieve an overall reduced follow up rate in line with plans within the sustainability and transformation plan
- Support for children and young people who are under the care of paediatricians in other areas/trusts where dual care is not required (e.g. under the care of another local trust i.e. Sherwood Forest Hospitals Trust or a specialist tertiary centre).

*Children who have appointments cancelled or who WNB will be offered alternative dates in line with organisation's WNB policies.

3.4.2 Adherence to Commissioner Policies

All aspects of this service specification must be fully complied with. If any aspect is not achieved this constitutes non-compliance and must be discussed with Commissioners at the earliest opportunity for a way forward to be agreed. , Procedures of Limited Clinical Value policy and the Consultant to Consultant Referral policy must be adhered to, alongside any subsequent pertinent commissioner policies which may be varied into the contract. The provider must support commissioners in local processes to ensure that all clinicians work to the thresholds and agreed approaches.

3.4.3 Follow-ups

The service will offer follow up appointments and reviews as clinically appropriate and in line with the agreed NICE Guidance and local pathways. Follow up appointments within Community Paediatrics will deliver clinical advice on managing the child or young person's health and treatment, and the monitoring and prescribing of medicines for which GPs or appropriately trained Community Pharmacists/Nurse Prescribers are not approved prescribers or where there are no shared care protocols.

This includes the on-going management of medical conditions associated with mild/moderate neurodisability (e.g. respiratory problems, epilepsy, feeding and nutrition, constipation and management of spasticity), excluding those covered by NHSE.

Annual reviews will only be offered where clinically necessary .

3.4.4 Daycases (BADS)

Not applicable.

3.4.5 Outpatient Procedures

Community paediatric provision is on an outpatient basis and should be delivered in a community setting or at the CDC where appropriate

3.4.6 Pre-Operative Beddays

Not applicable.

3.4.7 Pre-Assessments

Not applicable.

3.4.8 Diagnostics

All elements of the delivery of the service must include the provision of all basic diagnostic testing, support from nursing and ancillary staff and administration support required to deliver this service specification, whilst not duplicating any tests that have already been done in primary care. Assessment will be needs driven and not dependent on receipt of a specific clinical 'diagnosis'. Medical assessment includes but is not limited to investigations in haematology, biochemistry, metabolic, genetic and imaging tests as well as basic diagnostic testing.

Once assessment is complete the service will use their clinical judgement and results from test/investigation to make diagnostic conclusion with a written record of the outcome shared with the referrer, young person and their family/carer and, where required, other appropriate professionals.

3.4.9 Waiting Times

In order to identify and meet children and young people's outcomes in a timely manner the service must:

- Offer of care within 13 weeks of referral to all children and young people eligible for the service.
- Offer treatment within 18 weeks
- Signpost those who have been identified as requiring urgent intervention to an acute paediatric rapid access clinic/Emergency Department within a clinically appropriate timescale and no longer than 48 hours.
- Respond to requests for information, advice and input within statutory (or locally agreed) timescales (e.g. EHC plans).
- Provide support for a 24/7 out of hours (including Bank Holidays) service for children who are at end of life (e.g. for symptom, pain management and prescribing) delivered in conjunction with hospital based paediatricians, ICCYPH and GPs.

3.4.10 Other Requirements

- The service will be expected to abide by national and local requirements on issues such as prescribing for appropriate duration as agreed by the Nottinghamshire APC. This will include the requirements as outlined in http://www.england.nhs.uk/wp-content/uploads/2016/07/letter-contract-requirements.pdf.
- If the Provider starts to offer and charge for 'uncommissioned' services not covered by the intent of this specification, these will not be funded by commissioners unless actively commissioned as a result of a business case from the Provider which clearly demonstrates value and efficiency savings.
- In line with General Condition 15 of the NHS Standard Contract, commissioners may at any time request audits to ensure compliance with the criteria and thresholds detailed here. Commissioners will also consider the use of Prior Approval as per the NHS Standard Contract as necessary.

3.5 Interdependence with other services/providers

The service will work with numerous other disciplines in order to meet the service user's needs.

In particular for community paediatrics, a number of partnership working opportunities are presented within the wider local systems 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, Mid-Notts and Greater Notts Transformation programmes and STP. The provider will be required to work in partnership with health, education and social care commissioners and providers to move towards greater integration. This may include the integration or alignment of pathways, assessment, care planning and review processes, and/or co-location of services.

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

0-19 Public Health Nursing Services (Health Visiting, Family Nurse Partnerships and School Nursing)	111 emergency and urgent care services
Acute Emergency Departments:	Acute sector
Adults services (transition)	Bereavement services
Child and adolescent mental health services and professionals (including IMHA and IMCA)	Children and adults continuing care services
Children's Development Centres (CDC) colleagues	Children's occupational therapy services in local authorities
Clinical support to appropriate panels and forums	Commissioners
Condition specific Clinical Nurse Specialists	Designated Clinical Officer
Early support pathways/programmes/targeted support	Family Nurse Partnership
General Practitioners (GPs)	Health Clinic/Health Centre staff

Hospices	Information, advice and support services (IASS)
Integrated Community Children and Young People's Healthcare (ICCYPH) service	Interpreting services
Local Authority SEND including Integrated Children's Disability Service	Looked after children services
Maternity services	Midwifery
Nottinghamshire and Nottingham City Local Offers	Optometry and hearing services
Other Community paediatricians e.g. those delivering statutory provision and those within other trusts	Paediatric and neonatal intensive care units
Paediatricians in acute care settings	Parent/carer/family
Personal budgets and direct payments	Portage services
Primary Care Out of Hours services (e.g. NEMS and CNCS)	Safeguarding and Multi Agency Safeguarding Hub (MASH)
Schools – teachers, teaching assistants	Short breaks services
Specialist Dental services	Sure Start Children's Centres and Early Years services
Third sector providers e.g. Barnardo's, Ask Iris, Family Action	Transport services for children and young people with additional needs and disability

Relevant networks and screening programmes
The service is involved in a wide range of multidisciplinary and multiagency networks based around its key network planning groups and professional leadership areas:-

- Safeguarding
- Children in Care
- Special education needs and disability
- Vulnerable adolescents
- Emotional & behavioural problems
- Public Health
- Children with additional needs
- Undergraduate medical training
- Postgraduate medical training
- Continuing professional development
- Training/ education/ research activities
- SEND Accountability Board (County) and City equivalent work streams as required.
- DMO strategic partnership
- East Midlands Strategic Clinical Networks

3.6 Future Developments

The commissioner will work with the Provider and other partners within the network of provision for children and young people to:

- Review the assessment and diagnosis for ASD/ADHD to young people of secondary school age or above and their follow up care.
- Review the continence, constipation and sleep pathways so that the community paediatric service delivers the level of clinically appropriate provision.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

The service will comply with all relevant national standards, including those from NICE, and the Department of Health.

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

The service will comply with all relevant national standards from the Royal College of Paediatrics and Child Health.

4.3 Applicable local standards

The NHS and local health economies give better value for NHS users and taxpayers by using data and evidence to reduce unwarranted variation. We have used the commissioning for value packs which support the priority areas that offer the best opportunities to improve healthcare for populations and increase value. The specifics detailed in section 3.4 are intended to commission value and form the required local standards.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4 Parts [A-D])

Those requirements listed specifically within this specification plus those detailed in the relevant contract quality schedule.

5.2 Applicable CQUIN goals (See Schedule 4 Part [E])

5.3 Applicable Outcomes Measures

Those requirements set out in the appendix 2 – outcomes and quality framework.

5.4 Applicable Key Performance Indicators

Those requirements set out in the appendix 2 – outcomes and quality framework.

6. Location of Provider Premises

The Provider's Premises are located at:

Services will be locality based and the provider will ensure strong links, and optimising joint working 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 CCG the locality based hubs will integrate with the care delivery group 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 offered in a variety of locations and at times to meet the needs and, where possible, the 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:

- Health centres
- Community clinics
- Education settings such as schools, colleges and nurseries
- Early years settings such as sure start and children's centres, playgroups, private nurseries
- City hospital Children's Development Centre (CDC)
- Families' home
- Short break settings
- Other sites as applicable

7. Pricing and Reporting Requirements

7.1 Prices

- All prices are specified in Schedule 3 of the NHS Standard Contract.
- Applicable local prices are subject to negotiation.
- Activity should be coded and priced in line with Data Dictionary definitions

7.2 Reporting Requirements

The provider will work collaboratively with the commissioner in the first two quarters to refine and finalise the reporting requirements for the service within the local outcomes and quality framework. The provider will also respond to data requests from the commissioner to support service redesign and improvement, system configuration work and to meet any other statutory and strategic needs.

The provider will ensure streamlined and consistent performance and outcome monitoring and reporting on a quarterly basis in line with appendix 2.

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 commissioners will be provided.

Appendix 1 – Non-Statutory Community Paediatric led service

Nottinghamshire and Nottingham City Families Statement of Expectations (originally developed for the ICCYPH programme)

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 Non-Statutory Community Paediatric led service outcomes and quality framework

Each local service outcome below will be measured via a number of indicators/outcome measures, which evidences the contribution of this service to their achievement (to follow). The indicators will fall within categories i.e. Structure and Process; Satisfaction and Expectations (children, young people, families and workforce); Effectiveness (including clinical effectiveness/outcomes); Efficiency.

This framework sits within the context of the South Notts and Mid-Notts transformation programmes and the Nottingham & Nottinghamshire Sustainability and Transformation Programme (STP).

	Local Service Outcome	**NHS Outcome Domains**	**Applicable NHS 5-yr ambitions for improving outcomes**
1	Parents/carers are able to put being a family first and healthcare provider/s second. They are confident that they have the skills to care and advocate for their child through a genuine partnership with health professionals. Implicit in this is children, young people and their parents/carers are empowered to be involved in all decisions and are informed and supported.	2. Enhancing quality of life for people with long term conditions. 4. Ensuring people have a positive experience of care	2: Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions 3: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital. 6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community
2	Children and young people will maximise their participation in statutory education.	2. Enhancing quality of life for people with long term conditions.	2: Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions 3: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
3	Children, young people and their parents/carers have easy access to quality up to date information in relation to their condition and its impact on everyday life.	4. Ensuring people have a positive experience of care	6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community

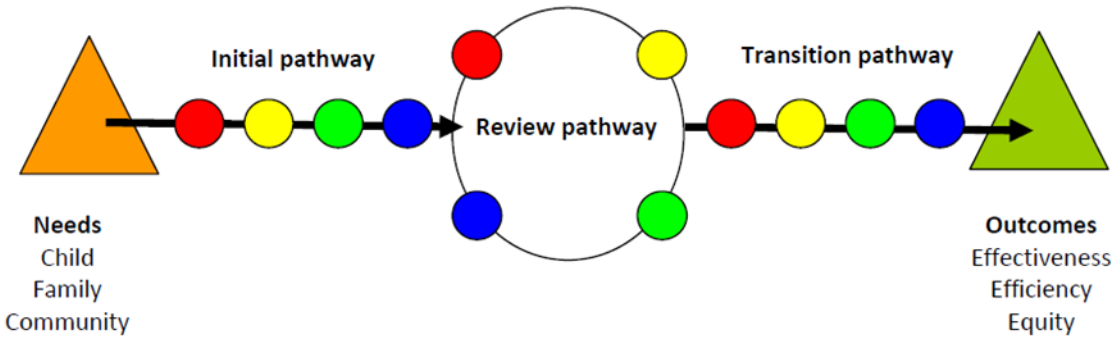
	Local Service Outcome	NHS Outcome Domains	Applicable NHS 5-yr ambitions for improving outcomes
4	Children, young people and their parents/carers have easy access to prescribed supplies and equipment.	5: Treating and caring for people in a safe environment and protecting them from avoidable harm	
5	Everyone involved in supporting the child/young person are involved, empowered and are working towards a continually improving shared plan and seamless care delivery.	4. Ensuring people have a positive experience of care	6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.
6	Every child/young person who needs care receives the care they need in a timely fashion.	1: Preventing people from dying prematurely	1: Securing additional years of life for the people of England with treatable mental and physical health conditions
7	Children, young people and their parents/carers have access to an appropriately trained, skilled and empathetic workforce who deliver care that meets the demand on the service.	5: Treating and caring for people in a safe environment and protecting them from avoidable harm 4. Ensuring people have a positive experience of care	7: Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care 6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community

	Local Service Outcome	NHS Outcome Domains	Applicable NHS 5-yr ambitions for improving outcomes
8	Young people and their parents/carers are supported to navigate the transition from childhood to adulthood/adult services and to understand the wider (including legal) implications of this. Implicit in this is that the developmental ability of the young person is taken into account and the NHS Transition Philosophy is adopted.	4. Ensuring people have a positive experience of care 2. Enhancing quality of life for people with long term conditions.	6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community 2: Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions 3: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
9	As a result of empowerment of everyone involved in their care children, young people and their parents/carers experience positive changes.	4. Ensuring people have a positive experience of care 2. Enhancing quality of life for people with long term conditions.	6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community 2: Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including
10	Children and young people are admitted to hospital or stay in hospital only when it is unsafe or inappropriate to care for them in the community. Implicit in this is consideration of the child/young person and their parent/carers' choice.	5: Treating and caring for people in a safe environment and protecting them from avoidable harm 3: Helping people to recover from episodes of ill health or following injury	7: Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care 3: Reducing the amount of time people spend avoidably in hospital

	Local Service Outcome	NHS Outcome Domains	Applicable NHS 5-yr ambitions for improving outcomes
			through better and more integrated care in the community, outside of hospital.
11	Children/young people are seen in age appropriate environments furnished and equipped to meet their needs, taking into account chronological and developmental age.	4. Ensuring people have a positive experience of care	6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.
12	The safety of the child/young person is paramount. This includes: a) Safeguarding b) Moving and handling c) Use of equipment d) Treatment and medications e) Psychological safety f) Relationships and Sexual Health g) Environment	5: Treating and caring for people in a safe environment and protecting them from avoidable harm	7: Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

Appendix 3 – Family Friendly Framework

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:

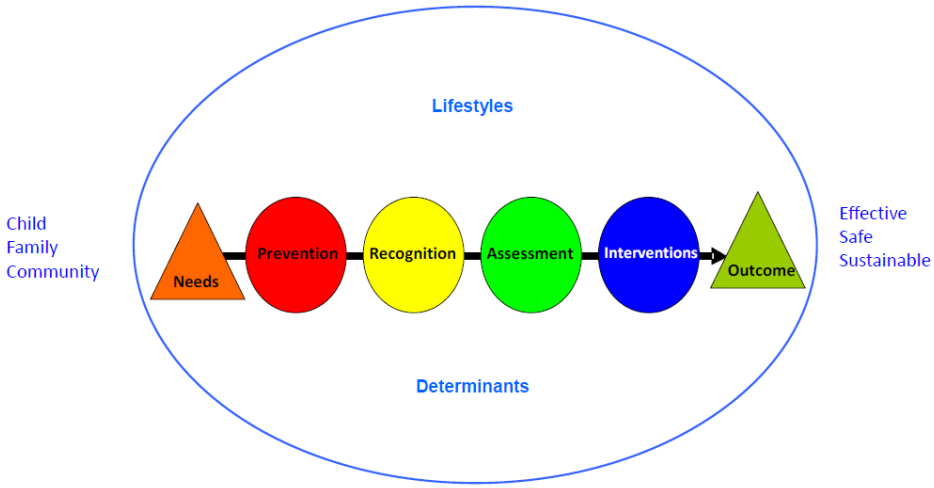


Illustration of the FFF long-term pathway with 3 phases – the initial, review and transition phases, each with four component parts.
(Source
http://www.bacch.org.uk/policy/BACCH%20Improving%20commissioning%20practice%20v17.2.pdf