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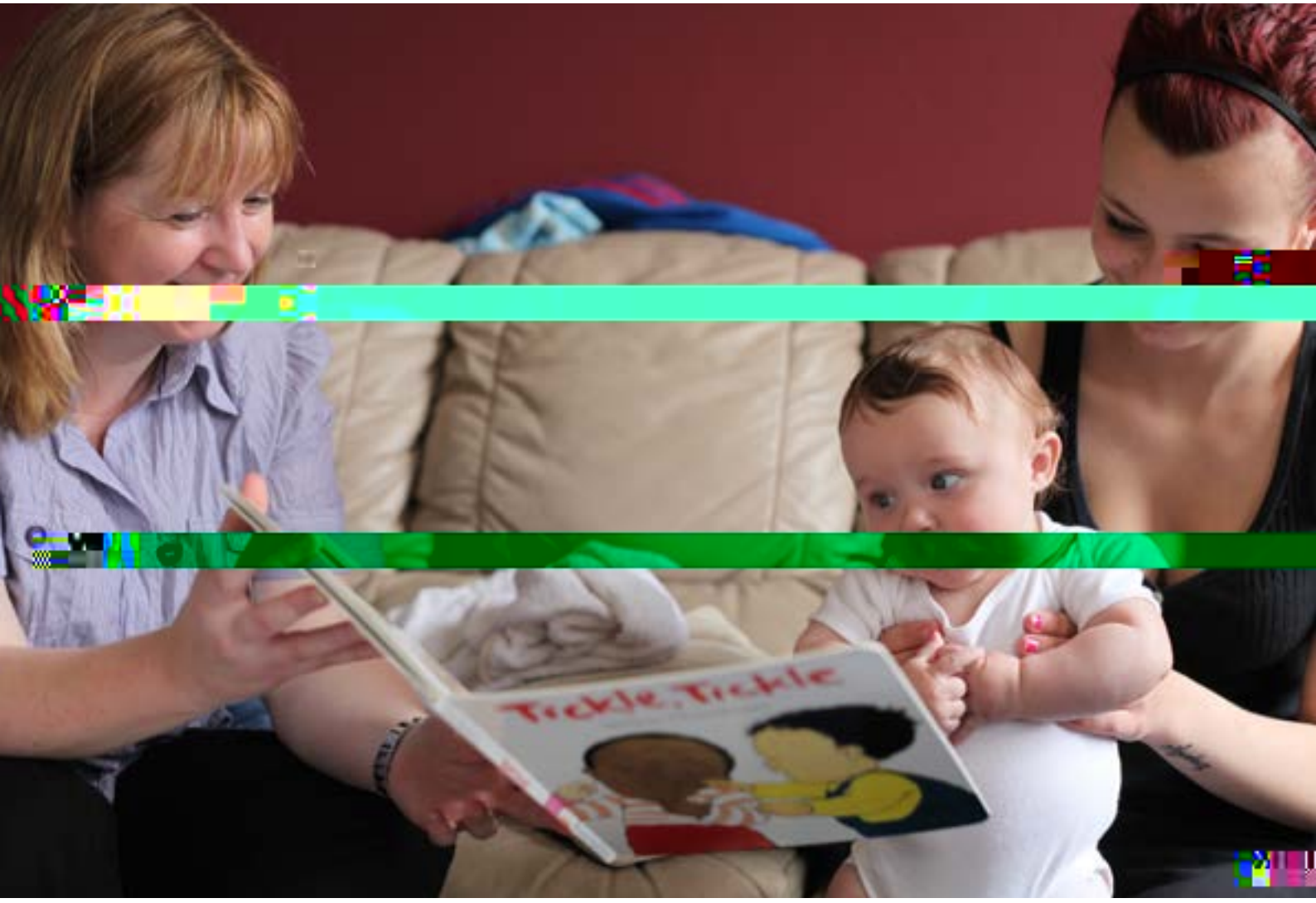
Futureproofing Community Children's Nursing

RCN guidance



Contents

This Royal College of Nursing (RCN) publication is for health care professionals, service providers and those involved with planning and commissioning services. It sets out the RCN's perspective on contemporary and future children and young people's (CYP) nursing services in the home and community setting. It also underlines the increasingly crucial role played by community children's nurses (CCN) as they provide integrated care closer to home.

The guidance explores the legislative and policy agenda, defines the role of the CCN, sets out the core principles of providing care, considers variations in how the needs of families are assessed across the four countries of the United Kingdom (UK) and outlines examples of current models of care and service delivery. It also covers:

- informatics and eHealth
- the school nurse role
- outcome measurement for families
- development of services (whilst ensuring sustainability of these services)
- planning for the future – how to meet the educational needs of professionals and develop future leaders in this field of practice.

Historically, community children's nursing has never had the support of an agreed UK-wide framework or universal offer as outlined within for example public health nursing (as with health visiting and school nursing). This leaves the CCN role as flexible and, seemingly, without boundaries. Within the four countries, developments and changes to the role will continue and, consequently, variation in each country will remain as practices evolve. As practice developments occur separately within the four countries, the RCN, as a professional body, needs to ensure good practice is communicated as widely as possible. Such dissemination will enable practices to align and reduce the variation across the UK.

Notably, Scotland has recently developed a framework for health visiting and school nursing. The basis of a universal offer for community children's nursing, as a distinct field of practice, is offered by work undertaken jointly by the Queens Nursing Institute, Public Health England and the Department of Health for England (2018).

In 2013, a review in Scotland of the public health nursing role, as defined within Nursing for Health 2001 (Scottish Government, 2001), was undertaken. A Chief Executive Letter (CEL 13) stated that the role should be refocused and the titles of health visitor and school nurse reintroduced (Scottish Government, 2013).

- The role of health visitor would focus on children 0 to 5 years of age, (including preconception) and the role of the school nurse would focus on school years (children aged 5 to 19 years).
- Health visitors and school nurses would continue to be on the third part of the NMC register (Public Health Nursing).
- There was an acknowledgement at this review that the role of the community children's nurse would need to be reviewed, along with the roles of the wider health team involved with children at school.

Subsequent changes, for example in the role of the school health nurse, echo the variation of service provision across the UK (Scotland reintroduces health visitor and school nurse). A refocus on the public health perspective, has led to CCN services needing to meet aspects of care which would traditionally have been provided by

Within the UK, the development of CCN teams were identified by the Department of Health (England) as significantly contributing to, whilst supporting the safe delivery of care to CYP and their families closer to home (Hinde, et al. 2016). According to Price (2018), the first CCN team was in Rotherham in 1949 (a historical timeline of the development of community children's nursing is included in Appendix 1). Since this time, CCN teams and associated services have established themselves as an important part of the interdisciplinary and multi-agency team, aiming to provide high quality, safe and effective care whilst working in close partnership with CYP and their families.

In 2011, the Department of Health in England described four categories of community care for nursing CYP (see below and in more detail later) and CCN services as 'the bedrock of the care pathways for these groups of children' (DH, 2011).

Four categories of community care for nursing CYP

- Children with acute and short-term conditions.
- Children with long-term conditions.
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and across organisations. The type of service provider also makes a difference to referral pathways and clinical governance arrangements for CCN teams (which enable the provision of safe and consistent care). Acute and community providers may have differing priorities, and interpretation of national policy is consequently reflected in the model of care delivered. Work being undertaking in Scotland is seeking to secure a consistent approach to delivery of services irrespective of location and provider.

The QNI and the Queen's Nursing Institute Scotland (QNIS) worked together with experts from across the UK to develop a set of voluntary standards to support community children's nurse (e)2.7 (.3 (e)T 10.4 (8.9 (f)]TJ3(y)1.5)9.7 (4)-18.1 (0 20.1 (.8 (N)-23. -0.01 ')53.8 (c)-28.7 (t)-(y)1.5)-2.8 (c)-23.9

For many years there has been an increasing emphasis and associated policy directives on meeting the needs of CYP and their families in the home and community setting. Within the four countries there is emphasis on a move towards integrated working across health and social care with joint or pooled budgets.

England

In England, several successive polices have been published which include:

- NHS at Home: Community Children's Nursing Services (DH, 2011)
- Five Year Forward View (NHS England, 2014)
- New Care Models – Vanguards (NHS England, 2016)
- The NHS Long Term Plan (NHS England, 2019).

These have led to a change of direction for health services. However, it is evident that the focus of these polices is not exclusively related to services for CYP. Importantly, the publication of The NHS Long Term Plan provides a clear commitment and identification of the need to develop age appropriate models of care and, significantly for CCN services, care delivered closer to home. It is also essential to develop locally agreed models of care for CYP in the community. These can help support an increasing urgent care workload and reduce the burden on acute emergency department resources, plus provide appropriate care closer to home. The NHS Long Term Plan also provides a commitment to the palliative care provision for CYP, having recognised that health care costs have outpaced investment and funding arrangements.

The Children and Families Act (2014) states that a child or young person has a special educational needs and disability (SEND) if he or she has a learning difficulty or disability which calls for special educational provision to be made for him or her. The accompanying Code of Practice requires commissioning groups to work together to ensure children and young people with SEND get the education, health and care services they need; this may be published as the local offer. The role and the scope of community children's nursing teams will be included and outlined in this offer.

Wales

The Social Services and Well-being (Wales) Act (Welsh Government, 2014) is fundamental in supporting partnership approaches to assessing and planning the care and support needs of children and their families. A person-centred approach is used to establish wellbeing outcomes for children. Local authorities and health boards are encouraged to work together and drive integration and innovative service change.

The above work is also supported by the Well-being of Future Generations (Wales) Act 2015 (Welsh Government, 2015) which has encouraged agencies to think differently and act collectively. A future vision of a 'whole system approach to health and social care' is outlined in A Healthier Wales: Our Plan for Health and Social Care (Welsh Government, 2018a). This publication supports models of seamless health and social care (with a shift in resources from hospital to the community) and encourages the growth of informatics and digital technologies across agencies to support safe high quality care.

The recent Additional Learning Needs and Education Tribunal (Wales) Act 2018 (ALNET ACT) aims to improve the planning and delivery of additional learning provision through a person-centred approach to identifying needs early, putting in place effective support and monitoring, and adapting interventions to ensure they deliver desired outcomes. A draft additional learning needs code for Wales (Welsh Government, 2018b) has recently completed the consultation phase (March 2019) and a definitive document is pending.

Professionals have a responsibility to support children with medical needs in education.

health nurse, school nursing (SCPHN SN), based on national public health programmes and outlines categories of universal, enhanced and intensive service provision.

Scotland

The review of public health nursing, health visiting, school nursing and CCN services for Scotland began in 2013. A Chief Executive Letter (CEL 13) (Scottish Government, 2013) stated that the current public health nursing (PHN) role, as defined within Nursing for Health 2001 (Scottish Government, 2001), would be refocused and the titles of health visitor and school nurse reintroduced. The role of health visitor should focus on 0 to 5 years (including preconception) and that of school nurse on school years (5 to 19 years). Health visitors and school nurses continue to be registered on the third part of the Nursing and Midwifery Council Register.

The health visiting, family nurse partnership and school nursing practice models and education programmes are complete. Work continues on CCN services, the wider health team for children in school and the nursing service for children and young people who experience the care system (formally known as looked after children).

The CCN National Review (in progress at time of this publication) aims to recommend a consistent approach to care delivery.

CCN National Review

- Explore and clarify the CCN role in Scotland.
- Clarify the interface between health visitors, family nurses, school nurses, care experienced children's teams and CCN teams.
- Scope the educational preparation required for CCNs.
- NHS Education Scotland, under the Transforming Roles Programme, to take forward discussion regarding CCN education provision in Scotland.
- Agreement on the educational preparation required for the CCN role.
- Clarification of career framework and links with children teams/roles.

The Facing the Future: Together for Child Health (RCPCH, RCGP and RCN, 2015) recommendations from the royal colleges, highlight the importance of the role of the CCN in service delivery which supports that of primary care services. An implementation plan has been developed and is being monitored in Scotland.

The nursing teams involved with the care and treatment in Scotland work in a multiagency model and abide by the Children and Young People (Scotland) Act 2014. The implementation of the National Practice Model for the care of all children in Scotland, Getting it Right for Every Child (GIRFEC), supports a multiagency joined-up approach to meeting children and young people's health and wellbeing needs.

Northern Ireland

Transforming Your Care. A review of Health and Social Care in Northern Ireland (Department of Health Northern Ireland, 2011) and Health and Wellbeing 2026: Delivering Together (Department of Health Northern Ireland, 2016a) are the overarching programmes of work aimed at further developing Northern Ireland's health and social care system, in order to meet the current needs of individuals and families, both now, and well into the future. Emphasis is on the provision of high quality care, increasing the provision of care in the home setting, preventing ill health, co-production and improving access to care.

Regional reviews of children's services have been conducted in Northern Ireland since 2013, culminating in the publication of A Strategy for Paediatric Healthcare Services Provided in Hospitals and in the Community 2016 – 2026 (Department of Health Northern Ireland, 2016b). This strategy emphasises the need to strengthen the links between community and hospital services, alongside services within, and between, hospitals. As paediatric services develop, there will be more emphasis on community teams, with input from a range of staff: children's nurses, allied health professionals, social care professionals and support workers.

Key drivers identified in this strategy include:

- an increase in birth rate
- an increase in children surviving with complex, long-term conditions requiring intensive support
- lifestyle factors that impact on the health and wellbeing of children
- the need for more sophisticated interventions
- changing models of care so that common conditions can be managed as day cases, without a need for inpatient admissions (Department of Health Northern Ireland, 2016b).

The skills and competences of children's nurses and advanced nurse practitioners (as part of the multidisciplinary team) are recognised as key to delivering high quality services. A regional assessment tool and Integrated Care Pathway for Children and Young People with Complex Physical Healthcare Needs (Department of Health Northern Ireland, 2009) are utilised by CCNs in partnership with families.

4. Models of community children's nursing services

According to The Future of Child Health Services: New Models of Care (Kossarova, Devakumar and Edwards 2016) new models of care have emerged to help promote the provision of joined up acute and primary care provision and to increase satisfaction with services. Moving forward, the use of eHealth strategies and telemedicine are coming to the fore, not only to assist record keeping and communication between professionals, families and agencies but also to influence how we communicate with CYP. The RCPCH's State of Child Health: Report 2017, suggested the use of email, websites and apps to enhance communication between individuals and professionals. Innovative practices such as these are coming to the fore and will impact on service delivery.

Whilst there are four distinct care pathways described by the Department of Health for England in 2011, the numbers of children in each category, and the location of services in many areas, do not naturally facilitate these services being provided in separate teams. However, in some areas these groups are commissioned separately despite there being obvious overlaps – for example, the child with complex needs may be receiving palliative care, alongside experiencing a short-term need for acute health provision. It may be helpful for health planners and commissioners to scope their local CCN service provision and ensure this is clearly outlined within a core offer.

Through the production of a localised core offer, and overarching joint service level specification for CCN services, service users could see a reduction in fragmentation and an increase in the integration of services delivered. CCN teams can still work with a specialist focus, but the significant factor is the associated creation of clearly defined clinical/service pathways (rather than a 'one size fits all' encompassing service) due to, for example, the differing nature of care delivered by acute or continuing care service providers.

Funding arrangements for such services in England vary and have been seen to evolve following a local review of services and national drivers. Funding considerations include: central government policy for the integration of health and social care budgets (NHS England, 2016) and the existence and development of local arrangements (as with local care partnerships where service delivery agreements exist between acute health trusts and community providers).

The publication would therefore encourage that services are reviewed, and this approach taken when recommissioning existing services.

Case study 2: Evelina London Children's at home and community nursing service

The Evelina Children's at home and community nursing team operates a seven-day service (8am to 10pm). It is an integrated model of care that has been jointly commissioned by Lambeth and Southwark and managed by the acute directorate of the Evelina London Children's Hospital.

The team operates out of three hubs (two hospital and one community), supported by mobile working on a virtual ward. There is a rapid response component to the team that can take a referral and review the child at home within three hours of discharge, up to three times a day, with clinical oversight from paediatricians. A daily huddle is held where teams from all hubs meet for handover, review, allocation and to ensure the team is working to full capacity at all times across the service.

Hospital bases and sitting in the acute directorate allow for increased visibility, raised profile of the CCNT and communication with ED/acute paediatric services, as well as increasing referrals, coupled with the clinician's confidence. Further opportunities for earlier discharge of different conditions can also be identified.

The overall aim is to reduce length of stay, admissions and ED attendance. The model allows for increased responsiveness and improved flow through a single pathway and point of access for children with acute/short-term, complex needs, continuing and palliative care from hospital to home, linking into primary care/universal services within the local community.

A pilot scheme is planned for GP referrals in the spring/summer of 2019 which will be supported by staff on the advance nurse practitioner (ANP) pathway, with ongoing management and referral into the wider team.

6 H U Y L F H L Q D F W L R Q

A complex needs child was admitted to the high dependency unit with a chest infection requiring a cubicle as MRSA positive. Once stabilised, it was identified the child could be managed at home for clinical review up to three times a day and IVAB (intravenous antibiotics). We were able to facilitate this quickly by referring into the rapid response team, while regular clinical review was needed, transferring into the team based in the community hub and on existing caseload to complete IVAB. This integrated model allowed for early discharge, decreased risk of acquired hospital infection and a responsive and seamless flow to home (and increased hospital capacity for further acute admissions).

The role of the CCN is clearly defined by the identification of, and requirement for, nursing care provision to be delivered at home or in a local community place of care, including school. Due to the variety of service models, CCN services need to be adaptable, some services will be co-located with specialist services, including clinical nurse specialists (CNS) and others in reach or outreach. Care is delivered on behalf of the specialist services, with the same endpoint of providing nursing care in the community. While it is generally accepted that this has a positive effect (Hinde et al, 2016), it is not without its challenges (Castor et al, 2017). For example, children experience a wide range of conditions requiring extensive knowledge, skills and expertise on the part of parents and professionals. Also, advancements in care have cont spe kn-18.1 (r)-5.6.3 (e)i 8 (t)-20. (i)-12.4 T38 (v)6.6 (e 9)4f ptrah t)-22; m6 (v8 (i)-12.4 T389(l)1 (e)]TJ 0 -1.2 Td [(
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This area includes neonates and those requiring and meeting continuing care criteria. There are now examples of integrated disability teams where the role of the CCN has become more focused on a social model of care; the CCN has taken on the role of keyworker for children with complex needs and consequently lead on care planning and person-centred reviews. Integrated multidisciplinary teams ensure a whole systems approach to the provision of holistic care for CYP and their families.

In some areas, special needs school nurses are responsible for leading care for children in special needs schools, assessing needs in school and working with school staff to ensure these needs are met. These school nurses often work alongside CCNs or make up part of the wider CCN team. This whole systems approach was explored by the British Association for Community Child Health and the British Association for Child and Adolescent Public Health, which jointly published Introducing the Family Friendly Framework (BACCH and BACAPH, 2014). This document was written in response to the free market approach to provision of children's services and a fear that fragmentation of services could impact on children's health outcomes.

CCNs, along with other health professionals, sit within the 'system' and form part of the child's health journey through levels of need using a graduated response model of addressing need. This means that care is provided by the right person at the right time and allows professionals to detect and react to changes as required. The skills required for a CCN working within complex systems are highlighted in The QNI/QNIS Voluntary Standards for Community Children's Nurse Education and Practice (QNI/QNIS, 2018), with a co-production approach to care planning alongside the management of clinical care and risk assessment.

Children with continuing care needs are required to meet national eligibility criteria, this means they can receive the bespoke care required to meet their assessed needs. An informal

Example model of continuing care

Background

Mark is 10 years old and has complex health care issues which he has had throughout his life. Over the last year he suffered from some severe respiratory issues which resulted in him being admitted to hospital and being ventilated approximately 20 hours a day via a tracheostomy.

Discharge planning

When Mark began to stabilise from the acute respiratory issues, the High Dependency Unit contacted the discharge coordinator in the hospital to begin planning for him to come home. As Mark's health needs had changed since he was last at home, a referral was made to continuing care for an assessment to take place. The continuing care nurse assessor working for the Clinical Commissioning Group (CCG) carried out an assessment of needs according to the National Framework for Children and Young People's Continuing Care (DH, 2016)* and came to the conclusion that Mark's health needs entitled him to a health support worker for five nights of care. This information was given to the family and to the discharge coordinator. Following the assessment, a joint hospital/community discharge planning meeting was arranged. The nurse assessor and discharge co-ordinator discussed who should attend and this involved the following groups/professionals from the community:

- a continuing care nurse assessor
-

Social services carried out an assessment and set up a respite service for the family at a local hospice as well as arranged provision of short breaks within the home via the direct payment scheme, allowing the family choice of how this was provided. All the changes in care were added to Mark's education, health and care plan by the special educational needs service. Throughout the planning process, the community team ensured the discharge planning co-ordinator was kept informed of progress.

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On the day of discharge, the community nursing team visited the family at home and were

More than 49,000 children and young people, including babies, are estimated to have life-limiting conditions in the UK (Fraser et al, 2012), representing a wide range of over 350 diagnoses. CCN services are a key part of the core children's palliative care services and are often described as the bedrock for good palliative care.

End of Life Care: Strengthening Choice: An inquiry Report by the All-Party Parliamentary Group (APPG) for Children Who Need Palliative Care (APPG, 2018) recognises that there are too few professionals with the skills, knowledge and experience needed to provide children's palliative care in hospitals, children's hospices and in the community.

RCN Competencies: Palliative Care for Children and Young People (RCN, 2018a) is a framework which sets out the specific competences required for nursing and support staff who work closely with families and other care providers to ensure the best possible quality of lebitr nhe c (o e)23.(r)0.5 (e)-10.2 3o-2q2 (n)-10.4 27.8 (8 (r63.4 (s)-1.(i)-12.4 6 (p)9.77 (d)7

Along with new models of service provision, novel approaches to educating the nursing workforce fit for the future are emerging. In England, the nursing associate role is emerging and will increase the opportunities available and the Nursing and Midwifery Council (NMC) has produced new education standards (NMC, 2018a) for implementation by 2020. This includes an increased emphasis on caring for individuals and families at home and closer to home. The NMC specifies (2018b) that all future nurses will need to work in a climate of continual change with shifting demographics, adopt different models of care delivery and embrace innovative practices and rapidly-evolving technologies. Additionally, the increasing integration of health and social care services will require registered nurses to play a more proactive role in interdisciplinary teams. These requirements have implications for future CCN teams.

The skills, knowledge and competences required for nurses working with CYP in the community requires future-proofing, nursing graduates to be flexible and able to access a varied career pathway. Simulation-based education is vital to future-proofing the whole CCN service; development of such simulation programmes is an integral part of education for future nurses/ community staff and parents. The establishment of these programmes will, no doubt, require an investment of time and finances (the full potential of mechanisms of simulation are yet to be seen). It is recognised by the NMC as an innovative and safe way to learn but work is required to ensure simulation-based learning meets the learning outcomes of the NMC sr4cogbd s4 (f t)-23 (h2.7 f)-32.-22.7 (u)-13 (r)-5.5 (e)-21.2 (-31 (m)-.)-4.4 (4 (e)-4.5 (g)-168 (386 44.05)-23 (T-12.9

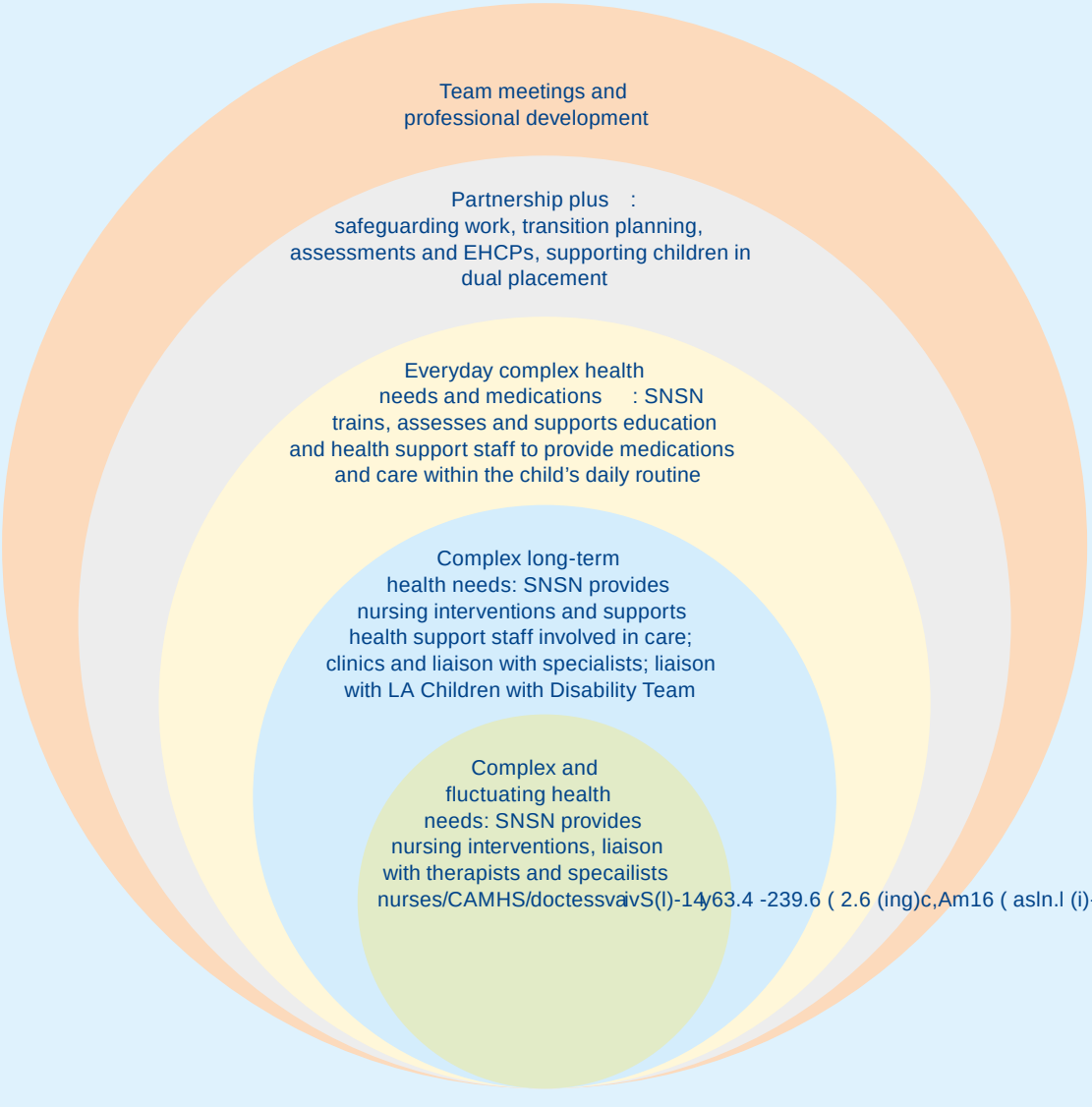
The impact of changes to the commissioning of public health in England to local authorities (Public Health England, 2018), has the potential to directly impact on community children's nursing. Whilst this move aligns children's public health alongside social care and education (preventing duplication of work), the local offer focuses on the specific public health interventions as laid out in the Healthy Child Programme (DH, 2009) and the National Child Measurement Programme (PHE, 2019) and does not include nursing support around specific conditions which may have been provided in the past or emotional and mental health. Although commissioning arrangements differ in the four UK countries, there is a similar focus on a core public health offer as described, for example, in the Welsh Government's A School Nursing Framework for Wales (2017b). This framework supports a universal and enhanced offer to ensure every child can access national screening, surveillance and immunisation programmes in the school setting.

In Scotland, The School Nursing Role in Integrated Community Nursing Teams (2018a) sets the school nurse's contribution within wider health and educational wellbeing teams in schools. This sits alongside announcements (Scottish Government, 2018b) of additional funding for school nursing to support children's and young people mental health services (CAMHS) interventions and a national review of CAMHS services.

CCNs have an increasing responsibility to contribute to health care planning for CYP in mainstream schools. This comprises a broad spectrum of conditions including: epilepsy, constipation management (continence), and allergy. The need for professional input into health care plans for children with complex needs is an accepted role for CCds ienomaote to (e)2.7 (r)- (d)-18.9 (rion)-2 hions i fbne110.2 (o)9.8 (n)-8 (a)-223 (l)]TJ 0 -1.2 Td [(f)-3.7(e)4nhn (i)2.7 ()6.7 ((n)-.1 ((s)0.-ad [(h).9 (p)6.3 (t)6.4 (e) (i)10.2

Together for Children and Young People was launched in Wales in 2015 by the Health and Social Services Minister. Led by the NHS, this multi-agency programme is working to reshape and refocus emotional and mental health services for children and young people in Wales, in line with the principles of prudent health and care. Other key school-based policies that are relevant to the role of the nurse in special schools are the roll out of the Healthy Child Wales Programme and emotional literacy and support mechanisms (ELSA) (Welsh Assembly Government, 2010).

Model for special needs school nursing



Whilst a lack of guidance regarding nursing in special schools in the UK is evident, Wales has however recently produced A School Nursing Framework for Wales – part 2: Nursing in Special Schools (Welsh Government, 2018c)

The Commissioning and Workforce Planning study aims to influence future policy for the provision of nursing in special schools, to produce a framework for children across the UK. A series of recommendations from the report are set out (see below) which will ultimately aim to set priorities for the provision of services within special schools. The Commissioning and Workforce Planning study aims to influence future policy for the provision of nursing in special schools, to produce a framework for children across the UK.

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- A model for health care provision is offered to ensure that children receive care that is appropriate for their needs and provided by people with appropriate knowledge and skills
- A minimum of one SNSN should be based in every school where there are children with complex fluctuating and complex long term health needs during school hours
- The SNSN should be care coordinator for those children with nursing needs
- There is a requirement for interdepartmental Government policy that specifically addresses the needs of this vulnerable group of children.
- A national, interdepartmental commissioning framework, based on current policy, is required to provide clarity and greater equality of health needs provision in special schools.
- The commissioning framework for this group of children should ensure that health needs are commissioned alongside educational provision.
- The commissioning framework should also include public health provision and take into account the local offer for children with disability in the local area.
- The director of children's services role should provide leadership in joint commissioning to ensure that public health, specialist health, social care and education needs are met.
- A multi-agency approach to all aspects of the service, from commissioning to evaluation of services provided, is required to ensure that all needs are met.
- A joint governance framework is required to incorporate health, social care and education services, ensuring consistency of approach and shared learning.
- Joint governance arrangements should be agreed to promote consistency in provision of health services.
- There is a need for continuing care panels to consider how health needs will be met in school.

CCN teams can only continue to deliver improved services if their practice is supported by the latest technology, such as mobile working, digital platforms, telehealth and text messaging. Using remote technology (iPads and laptops) enables the CCN to instantly access clinical records to help improve patient care.

Having systems that share key patient information between health partners is essential to ensure clinicians have all relevant, available information about a patient when making decisions about their care (RCPCH, 2015). Data shared by organisations includes information on: encounters, admissions and referrals, problem history, care plans, alerts, medications, investigations, planned out-patient appointments, hospital admissions, ED attendances, child health immunisations, radiology reports and blood results. Having immediate access to key clinical information and details about all individuals involved in a person's care will help:

- prevent unnecessary admission/readmission to hospital
- prevent delayed discharges
- support faster rehabilitation
- prevent unnecessary referrals
- prevent unnecessary home visits
- enable better triage of referrals
- support faster and more effective assessment
- reduce administrative tasks, freeing up time for clinical care
- improve the patient's experience (reducing repetitive questions).

CCN teams should consider online 'one stop' resources as a source of self-help for CYP and their families – these provide opportunities to undertake health screening which, when completed, provide individually tailored advice and information. Depending on the results, the site can offer users the option to self-e 4re odras.7 (d)9topaiv3 for the CYP. A CYP, parant or carer, and any professional workinag with the family (health, social and education, are able to utilise the platform to access up-to-date health care plans, medcation prescription information, as well as to.eaput feedback (such as sleep ds.7 (9 (i)-4.1 (a)-18.1 (r)-28.1 people – speaking with 17.9 4 (o)3.6 (v)6.6 (e)-10.1 (d o)9.5 (n)10

12. Lone working and safety considerations

Due to the nature of working in the community setting, staff members involved in the process of lone working are required to risk assess. This assessment covers the procedures they will undertake and their own individual safety. The risk assessment should cover the:

- individuals they are visiting
- geographical location of the visit
- time/day of the visit
- equipment and medication being transported
- ability to park close to the residence or location of the visit
- provision of a mobile phone or device to support with lone working
- administrative support to track visits/act as a buddy.

Furthermore, professionals have a responsibility to consider the safeguarding needs of the individuals and environment where care is to be delivered.

Risk assessments should be undertaken in a systematic and structured way. The process of risk assessment needs to be undertaken prior to arranging a visit with consideration to a known risk, and significantly dynamic risk assessments need to be carried out on each visit. An example of a risk assessment framework is provided in Appendix 2. Ideally, the information contained within the risk assessment should be in an electronic format available to all professionals and accessible remotely through the use of electronic devices and electronic patient records; this will help support and enable real time live documentation.

Information technology/ tele-health

Benefits for patients

- Provides greater patient choice and potentially enhances the patient's experience.
- Helps patients who have difficulty taking time off work to attend appointments, as no travel time is required and saves them time and money.
- Enables carers to attend from a different setting to support the patient, for example, even if they are at work.

Benefits for staff

- Virtual appointments may be a solution in settings where 'did not attend' (DNA) rates are high.
- Able to use video calls for clinical use at MDT meetings, group therapy sessions, GPs, ward rounds and local authority meetings.
- Virtual appointments helps to read a patient's body language and facial expressions, providing more information than a telephone call.
- Video calls can also be used for one-to-ones and management meetings to reduce wasted travel time and expenses claimed.

Benefits for carers

- Carers can attend either physical meetings between patient and clinician or virtual appointments remotely; this helps with being more closely involved in the patient's care.
- Allows carers to 'join' appointments even if they are not physically able to attend.
- Enables a carer to feel more involved.
- Enables a patient to chat with carers/ family members during inpatient stay.

An integrated electronic patient record (EPR) system, the Wales Community Care Information System (WCCIS) is being introduced throughout Wales which can allow health and local authority teams to share case management through one record for every person in Wales. A nationally agreed EPR framework that meets NICE Guidance and CQC regulation, whilst providing clinical templates for assessment and measuring outcomes is recommended by the RCN to support the development of CCN services and care for CYP closer to home/in the community.

Effective record keeping is the fundamental basis of all clinical care. This method assures professionals and patients that their discussions, decisions and outcomes are recorded both for future use, for use by other clinicians, and to report on progress and determine the outcomes and effects of treatments. Organisations must be committed to the implementation of a single ERP, available to staff in all locations and at all times; for the CCN, the EPR needs to be one that has the ability to work remotely, whilst meeting best practice and regulatory requirements.

Often, the CYP with complex needs has several medication administration records, depending on the settings they attend. Electronic charts that 'follow' the CYP, support the recommendation for a single record, reduces the risk for medication errors and, where appropriate, saves time in prescribing arrangements for the CCN. Enhanced systems support medication management assurances by providing audible alerts when a medication is due and keeps a record of the amount of medication left for checking.

In 2016, an NHS Improvement Patient safety alert (NHSI, 2016) tasked all NHS funded care providers to have a system in place by 31 January 2017 for recognising and responding to the deteriorating child. Paediatric Early Warning Scores (PEWS), previously used within acute services, need to be fit for purpose in community settings and support new ways of providing care closer to home and avoid unnecessary hospital admission (See Appendix 3: Community children's nurse home assessment tool). The home assessment tool provides the basis to undertake an initial physiological/emergency assessment of a CYP's clinical status.

CCN teams should also have appropriate business contingency plans in place. These will support a manager's planning and continuity of service delivery during unplanned staff absences. The plans can be RAG rated in terms of staff at 100%, 50% and 25% staffing levels (See Appendix 5: Community Nursing RAG Contingency).

CCN teams need to clearly identify what they can provide training for and the associated costs for such training provision to external agencies. In this way, CCN teams can confidently advise other services on what training falls outside of their core offer but can be commissioned/bought in. This practice is evident within therapy services and more recently seen within school nursing provision. CCN services need to align with this or they will struggle to meet a growing demand and the competing needs. Time investment will be required to consistently provide training, but this can be a further source of income generation for CCN services.

CCN services should be focused on meaningful person-centred outcomes for individuals and carers, valuing impact rather than individual contacts or tasks (Evans, 2015). Commissioning CCN services should include special needs school nurses and a move from block contract

The complexity and scope of CCN services is often poorly understood (Parker et al., 2006; Pontin and Lewis, 2009; Carter et al., 2012; RCN, 2014). CCN work encompasses multiple challenging issues which are compounded by:

- the diversity of different CCN service configurations employed nationally
- advances in medical technology that enable children to receive increasingly complex, life-sustaining health care at home
- the ongoing government agenda to provide more care at home (Department of Health, 2011; RCN, 2014).

Contemporary CCN caseloads are therefore ever evolving, dynamic domains, ranging from basic injections and dressing changes to highly complex packages of care for children with long-term ventilation and other invasive health care needs (Carter and Coad, 2009; RCN, 2014). Unfortunately, there is a paucity of literature that captures both the scope and complexity of the CCN caseload whilst also offering a means of managing this effectively.

Effective management tools can be used to ensure that caseloads are reasonable and manageable in size, highlight risks and issues and support the best use of scarce resources (QNI, 2009). Yet, currently, there are no universally agreed effective caseload management systems available to support staff with this crucial element of their work

Caseload management in community children's nursing: an action research project, Mulcahy (2015) (unpublished)

A local service development project was undertaken using action research methodology with the aim of developing an effective, caseload management tool. Action research offers a practical, collaborative approach to professional enquiry that is rooted in practice and strives to problem solve through reflection and cyclical re-evaluation of action: Observe – Reflect – Plan – Act – Repeat (Bowling, 2014; O'Leary, 2013). In this action research project, data was generated through a series of six, monthly focus groups using the skill and experience of a small, generic CCN team.

Evolving versions of caseload management tools were evaluated and re-designed to make them fit for purpose. This resulted in a dependency-complexity matrix and caseload monitoring tool (See appendices 5 and 6). The complexity score can then be reflected in a patient database, highlighting an individual patient's 'complexity' scores. The research identified: the need to articulate clinical risk effectively; the crucial and legitimate role of professional judgement in identifying patient dependency and complexity; the value of triangulating caseload information to facilitate comprehensive and robust caseload management.

Exposing the complexity of their caseload allows the CCN team to demonstrate factually and transparently what their professional judgment indicates. This knowledge allows the team to critically review the scope of the caseload to highlight risks and support effective and equitable caseload management decisions. It also supports escalation of issues to management and commissioners where necessary.

Further work is needed to explore the validity and potential transferability and adaptation of these tools throughout the UK, and adoption at a local level and associated use by CCN teams; this is evolving work and new 'risk' categories have now been added following feedback.

This RCN guidance highlights the evolving landscape of contemporary CCN services and its challenges, but recognises the opportunity for the innovative development of services in managing community children's nursing care across the four domains identified by the Department of Health (2011). Those working within and leading this field of practice need to understand the challenges and be responsive to this evolving health system. Key issues include: policy drivers, workforce, technology, financial consideration, and the widening health needs of CYP. There is also an increasing need for safe and comprehensive CCN provision closer to home, supporting health care provided by the acute sector.

Identifying key elements will require UK-wide consideration and will enable consistent care delivery and service provision, but local adoption of such factors should remain to ensure the needs of the CYP population are met. By applying a futureproofing approach across the UK, CCN

Additional Learning Needs and Educational Tribunal (Wales) Act 2018. Welsh Government: Cardiff. Available at: Z Z Z O H J L V O D W L R Q J R Y X N D Q D Z s q r y s F R Q W H Q W V H G 1 0 F W H G (accessed 10 October 2019)

All-Party Parliamentary Group for Children Who Need Palliative Care (2018) End of life care: strengthening choice. An inquiry report by the All-Party Parliamentary Group

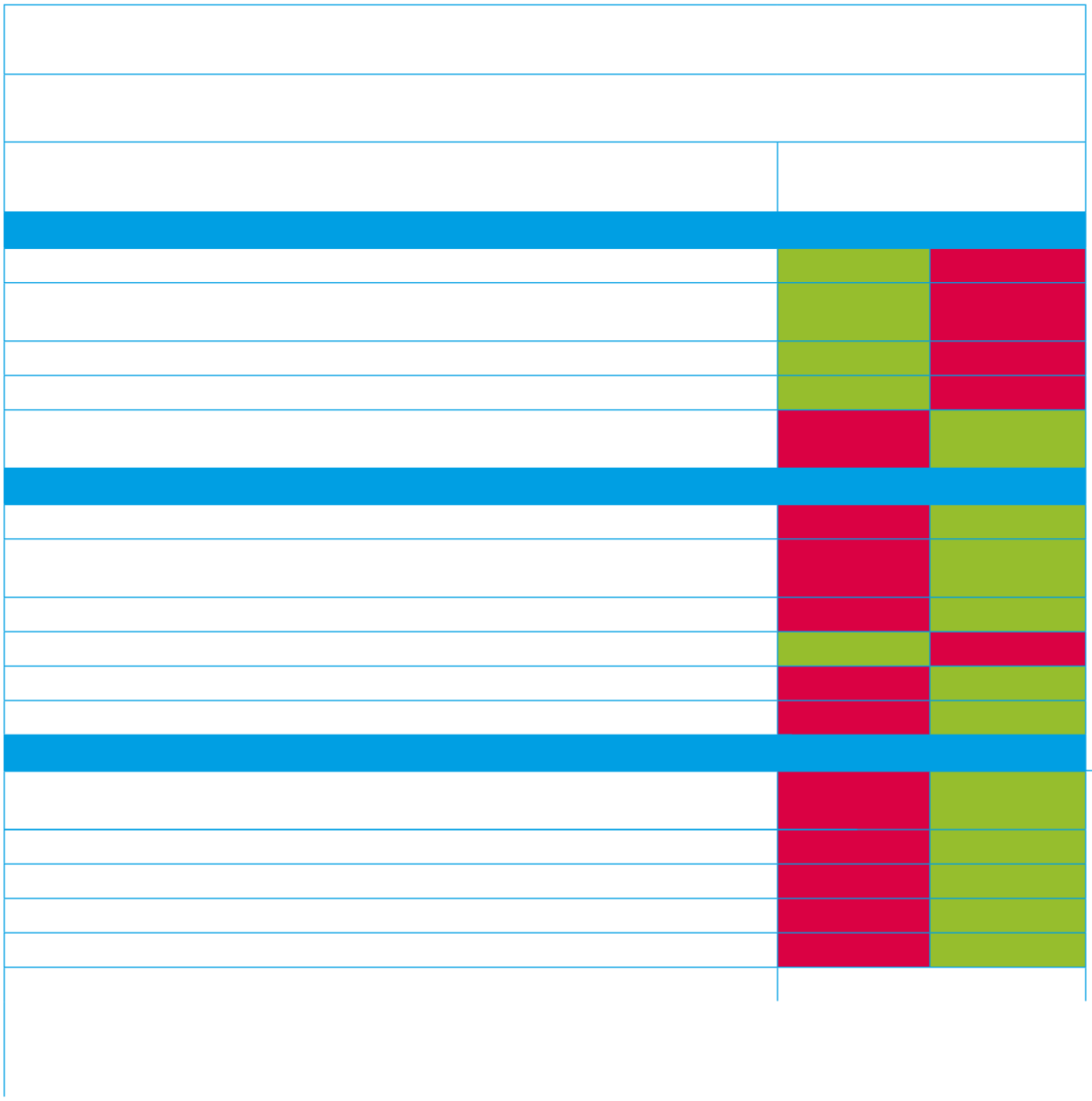
Royal College of Paediatrics and Child Health
(2017) State of c-.9 (.6 [31.4 (l11.1 (dh)11.1 (e)50.5 a)-0.5 l)-3 (t.4 (-1 (.: Rl)1128 (e)-1028 p)-74 (o83 (r)-16.5 t 2)43.1 (

736(o)751 0 -1 7 -1)] 704 (a)8 c7 e e 1

Welsh Government (2018c) A School Nursing Framework for Wales – part 2: Nursing in Special Schools Cardiff: Welsh Government. Available at: KWWSV JRY ZDOHV VLWHV GHIDXOW ILOHV SXEOLFDWLRQV sqrz qt D VFKRRO QXUVLQJ IUDPHZRUN IRU ZDOHV SDUW s QXUVLQJ LQ VSHFLDO VFKRROV QRYHPEHU sqry SGI (accessed 10 October 2019)

Whiting M (2012) Impact, meaning and need for help and support: The experience of parents caring for children with disabilities, life-limiting/life-threatening illness or technology dependence, Journal of Child Health Care, 17(1):92–108.

Author/title	Country	Date	Key messages
Department of Health, Children and Young People Outcomes Forum Recommendations to improve children and young people's health results: pe5i.2 (i)-8e.2 (r5 T[(i)5.1 (n)60 0 1 273.24 r)-_13.06(d)4.4E 0.259 2 [(pTJ um)]TJ4J um (i2)-19.91 01 (t)17.1.64 0 l 88 (n)-1]TJ 0.017 Tc -0.06e imndrum			



Appendix 3: Community children's nurses home assessment tool

Bristol Royal Hospital For Children

NHS University Hospitals Bristol NHS Foundation Trust

Community children's nurses home assessment tool

Clinical guidance to assessing children – to be used in addition to clinical expertise

	Green signs Low risk No action/give appropriate advice/ plan next CCN visit	Amber signs Intermediate risk Medical team/CNS advice or GP attendance	Red signs High risk 999 or Immediate ED attendance
AIRWAY	x Airway patent (including use of adjunct)	x Wheeze x Stridor	x Airway compromised x Airway obstructed x Foreign body
BREATHING	x Normal breathing pattern	x Nasal flaring x Subcostal recession x Head bobbing x Intercostal recession x Tracheal tug	x Grunting x Sternal recession x Poor respiratory effort due to exhaustion x Silent Chest x Too breathless to complete sentences or eat and drink
	x Normal colour of skin lips and tongue	x Pallor x Clammy	x Ashen x Blue

Bristol Royal Hospital For Children

NHS University Hospitals Bristol NHS Foundation Trust

Community paediatric early warning (PEW) score and physiological ranges for children

Adolescent's age >12 years

PHYSIOLOGIC PARAMETERS	4	2	1	0	1	2	4
Respiration Rate	G í ì		11-15	16-25	26-30	31-35	H ï ò
Oxygen Saturations	G õ í 9		õ î 9õ ð 9	H õ ñ 9			
Respiratory Distress				None	Mild	Moderate	Severe
Temperature	G ï°C			35.1-38°C	38.1-ï ðC	ï õ X40°C	G ð Ï°C X í
Systolic BP	G õ ì	õ í100		101-130	131-140	141-150	H í ñ í
Heart Rate	G ñ ì	51-60	61-70	71-100	101-120	121-130	H í ï í
Capillary Refill Time				0-2 secs		H ï •	
Level of Consciousness							

ACTION

- If red or amber signs are triggered please do observations using the Community Paediatric Early Warning tool.
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- SBAR report any concerns to the c

Service	Fully established Services provided	15% absent staff Services provided	30% absent staff Services provided	50% absent staff Service provided
Children's continuing care	• Management of fully established care package provision • Provision of on call service • Management of new continuing care assessments and re-assessments • Competency training • Monthly auditing of records • Safeguarding – core groups, conference and strategy meetings • TAC & CHIN meetings	• Management of health continuing care provision • Safeguarding – core groups, conference and strategy meetings • Provision on call • Management of new continuing care assessments • Competency training • TAC and CHIN meetings	• Management of health continuing care reduce service in accordance to priority requirements within pathway • Safeguarding – core groups, conference and strategy meetings • New competency training	• Management of health continuing care reduce service in accordance to priority requirements within pathway • Safeguarding – core groups, conference and strategy meetings
Service	Fully established Services provided	15% absent staff Services provided	30% absent staff Services provided	50% absent staff Service provided
Communituiinohiinavid iucee rd efreqgemagement reqece1-88 (r)1riemp69s p5 • - S6.9 (d)l2.65d– -erwwr t.7 (w)1.kdng Tf 0 Tc 0 Tw -1.063 -1.600• SafeL8.1(3)-8.8 (f)-8.9 1 (e)-g 0 2d3 ty008 Tw 0 66 2Td [(S)-1 •]TJ (a 0tt11i)69 884 3 •				

The community children's nursing (CCN) caseload complexity matrix is intended to demonstrate nursing need through identification of the frequency of intervention and the duration and complexity of nursing care intervention(s) undertaken. The final score is achieved by plotting the frequency of nursing intervention against the complexity of intervention:

Caseload scoring matrix

Complexity						
6	6	12	18	24	30	36
5	5	10	15	20	25	30
4	4	8	12	16	20	24
3	3	6	9	12	15	18
2	2	4	6	8	10	12
1	1	2	3	4	5	6
		1	2	3	4	5	6

Frequency

	Green (Low) <6
	Yellow (Low – Medium) 6–14
	Amber (Medium – High) 15–23
	Red (High) >23
	Dark Red (Very High) 36

Notes regarding use of the matrix:

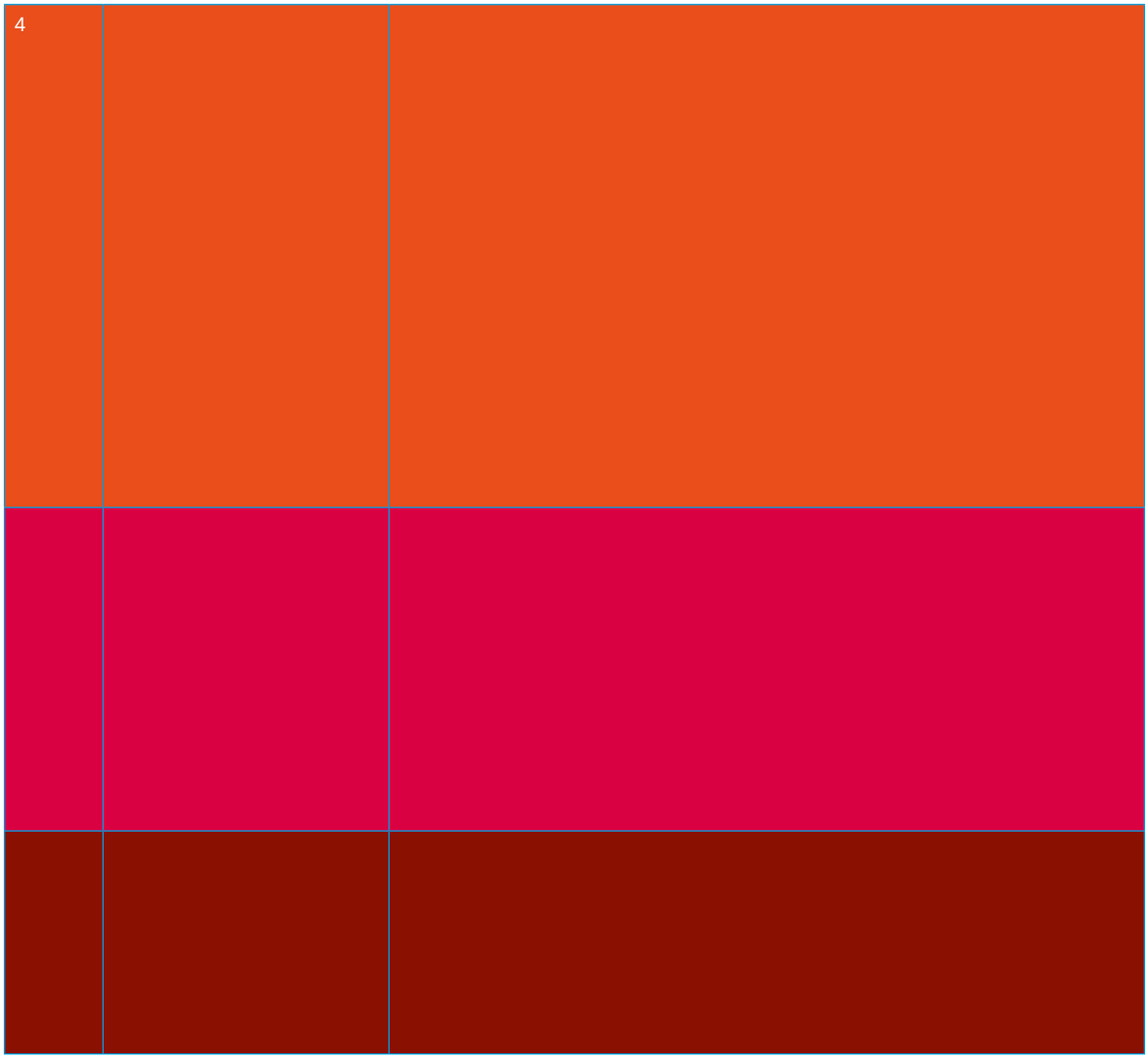
The scores identified are a guide only and can be interpreted by the individual practitioner to support their final score for each specific child. There will not be a category that directly aligns with every patient and knowledgeable, pragmatic professional judgement should be used to determine appropriate scoring in relation to other patient scenarios. The matrix is based on a stepped approach so where nursing care needs exceed the level described there is a need to 'step up' the level to a maximum of Level 5.

The highest Level 6 is reserved for the most complex End of Life (EOL) scenarios or where highly complex children and young people (CYP) are discharged home with Long term Ventilation and other complex ca.1 (p)17.9-u488c8

Community children's nursing caseload dependency – complexity matrix

Complexity descriptor

Score	Approximate time for	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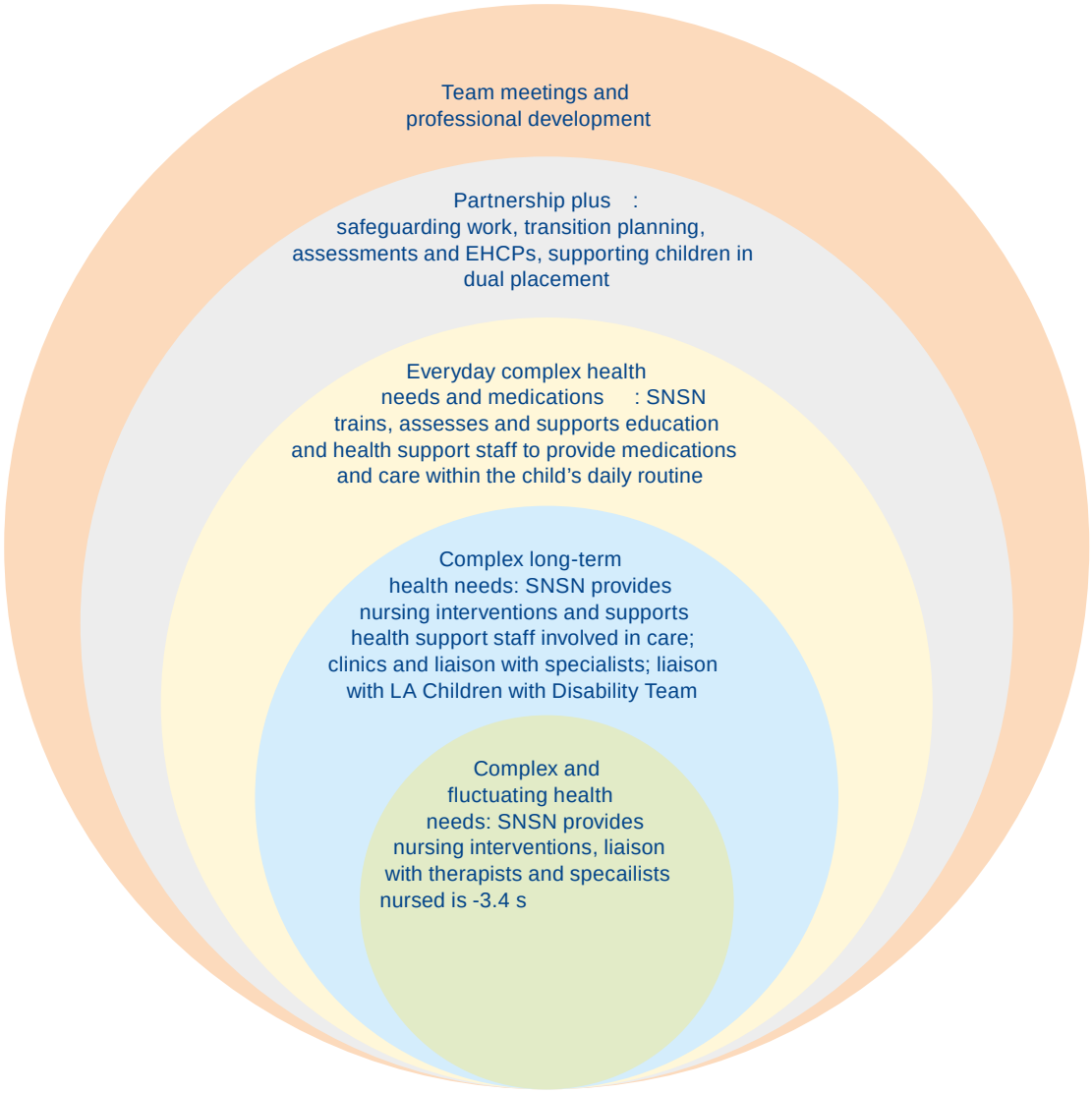
Appendix 6:
Caseload monitoring tool

Date:	High + Dark red	High Red	Med Amber	Low + Yellow	Low Green	Total caseload
No. of CYP						
Admissions						
Discharges						

Specialist high–risk intervention/care	No. of C/YP
DNACPR/ACP	
Oncology	
EOL (active management e.g. last 3/12)	
Safeguarding: on child protection Plan	
Safeguarding: active intervention / enhanced care e.g. Family of concern, TAC	
Looked after child (LAC)	
Tracheostomy	
Invasive ventilation and tracheostomy	
Non-invasive ventilation	
NPA	
NGT	
Sub-cut methotrexate	
Daily IV intervention e.g. antibiotics or cytarabine administration	
Identified pressure damage	
Other: high risk/acuity clinical pressures/risks/issues:	

Access to a specialist school nurse for children and young people with special educational needs is variable, with wide variation in models of provision across the UK[1,2] and much of the health care provided by school teaching support staff. There is no specific policy or guidance that covers meeting the health needs of children in special educational needs schools, except in Wales where a framework was published in 2018.[3] This uses

Model for special needs school nursing



Carol Williams (author of Special Needs School Nursing Project report), November 2019