

Acquired Brain Injury

Policy	Estates
HR/Workforce	Performance
Management	IM & T
Planning	Finance
Clinical	Partnership Working

Document Purpose Best Practice Guidance	
ROCR ref:	Gateway ref: 4284
Title	Acquired Brain Injury, National Service Framework for Children, Young People and Maternity Services
Author	DH
Publication date	15 Dec 2004
Target audience	PCT CEs, NHS Trusts CEs, SHA CEs, PCT PEC Chairs, Special HA CEs, GPs, SHA Children's Leads, NHS Trusts Children's Leads, A&E Departments, Ambulance Trusts, Children's Hospices CEs, Local Authorities, Other Government Departments, Copies to NHS Foundation Trust for information
Circulation list	
Description	This is the exemplar on Acquired Brain Injury which forms part of the National Service Framework for Children, Young People and Maternity Services.
Cross ref	Children's NSF
Superseded docs	N/A
Action required	N/A
Timing	N/A
Contact details	Claire Phillips, Children's NSF Team, 526 Wellington House 133-155 Waterloo Road, London SE1 8UG. Telephone: 0207 9724908. www.dh.gov.uk
For recipient's use	

Introduction

The National Service Framework (NSF) for Children and Maternity Services will be published alongside supporting material, which includes a series of exemplar patient journeys. Whilst it is not the role of the NSF or the exemplars to provide detailed clinical discussion on individual childhood conditions or aspects of pregnancy or childbirth, exemplars illustrate some of the key themes in the NSF.

Several factors influenced the selection of exemplar conditions, for example: large numbers of children and families affected, significant cause of illness and distress, wide variability in standards of practice or service provision, and suitability for highlighting the NSF themes. Such themes include the importance of responding to the views of children and their parents, involving them in key decisions, providing early identification, diagnosis and intervention, delivering flexible, child-centred, holistic care, which is integrated between agencies and over time and is sensitive to the individual's changing needs. It is also acknowledged that not every child with the same condition will follow the same journey or have the same type or severity of condition as the one which is illustrated.

The primary audience for the exemplars is professionals from a broad range of backgrounds including education, NHS, social services and the voluntary sector (although they could also be of interest to parents and older children). The exemplars may be useful in a number of ways, for example, to:

- > Highlight further references, which relate to evidence in the NSF and elsewhere, including key clinical guidelines;
- > Stimulate local debate and assist multi-agency partners to re-evaluate the way they collaborate on, commission and deliver children's services, for this and other conditions, to the benefit children and their families;
- > Provide an aid to examining and improving local clinical & non-clinical governance;
- > Provide a multi-disciplinary training tool for staff working with children and young people to raise awareness of specific issues and stimulate discussion;
- > Canvass the views of children and families on specific children's issues (eg via focus groups), provide a non-threatening mechanism to open discussion, such as good and 'not so good' aspects of the current service, and
- > Provide a starting point or template for debate, prior to development of new local strategies for managing complex childhood conditions.

Jack's Acquired Brain Injury (ABI)

Jack, aged 8 years, was escorted to school everyday by his mother. Usually they crossed the road via the zebra crossing close to the school gates.

One morning before they reached the gates, Jack wanted to cross the road to see a friend who was on the other side. Unfortunately, he did not have a clear view of the road, due to the parked cars. When he stepped into the road, a passing van, which was going too fast, was unable to stop in time. Jack was thrown some distance, hitting his head and sustaining multiple injuries.

	Journey	Children's NSF Theme	Evidence/Links
<p>Seeking Treatment √</p>	<p>> The emergency ambulance is called by onlookers and arrives promptly within 5 minutes. Jack remains conscious. He is assessed and initial management instituted (airway optimised, breathing assessed, oxygen given, circulation assessed and spinally immobilised on scene). To minimise pre-hospital time, Jack is given pain relief and IV cannulation in the ambulance, during transfer to the nearest A&E Department. His mother is able to accompany Jack in the ambulance.</p>	<p>Standard 1 & 3 – timely access to treatment</p>	<p>Ambulance response times – category A – 75% response time within 8 mins</p> <p><i>Head Injury; Triage, assessment, investigation & early management of head injury in infants, children & adults, National Institute for Clinical Excellence, June 2003 – pre-hospital management.</i></p> <p><i>Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines; section 6, paediatric trauma emergencies, 2004</i></p>
<p>Accident & Emergency Department (A&E) √</p>	<p>> Jack is taken to the Children's Unit at the A&E Department of the district general hospital, which is run by paediatric trained staff. Following initial triage and investigation by an A&E consultant and advice from an orthopaedic surgeon, Jack's physical injuries are diagnosed as bruising to the side of his head, fracture of left forearm, with soft tissue injuries to the face and hands. Jack is treated in A&E Department as appropriate for these injuries [eg plaster of Paris (POP), sutures]. In view of the head injury, he is to stay in hospital overnight to monitor for possible intracranial injury. A paediatrician is called to see Jack before admission to the children's ward.</p>	<p>Standard 1 & 3 – timely access to treatment</p> <p>Standard 6 & 7 – care in a child-friendly environment</p>	<p><i>National Standards, Local Action; Health & Social Care Standards & Planning Framework 2005-2008, Dept of Health 2004</i></p> <p><i>Appendix 1: existing commitment – maximum 4 hr wait in A&E from arrival to admission/transfer/discharge.</i></p>

		Journey	Children's NSF Theme	Evidence/Links
<p>Accident & Emergency Department (A&E) (cont.)</p>	<p>√ √</p>	<ul style="list-style-type: none"> > Jack's father at the hospital by car, when he hears of his son's accident. The doctors keep Jack's parents informed of his condition. They are also offered support and practical assistance by the nursing staff. > Just before transfer to the paediatric ward, the nurses raise concern about Jack's neurological observations because his pupils have become unequal size. Jack's condition suddenly deteriorates, he starts to 'fit', stops breathing and requires resuscitation, intubation and ventilation. The paediatrician calls the paediatric intensive care consultant, who is asked to re-assess Jack. They then call the specialist paediatric intensive care unit (PICU) at the neurosurgery centre 30 miles away and agree that urgent transfer to PICU is necessary. The paediatric intensive care consultant also recommends other immediate treatments because of the urgency of the situation (a probable extradural haemorrhage.) Jack is taken by emergency ambulance with life-support facilities and is accompanied by a consultant anaesthetist, rather than waiting for the retrieval team. > A&E staff check Jack's parents' arrangements for travelling to the tertiary centre and are assured that friends will give them a lift and take care of their other children. 	<p>Standard 2 – supporting parents</p> <p>Standard 6 & 7 – access to appropriate care and staff trained in the care of children</p> <p>Standard 2 – supporting parents</p>	<p><i>Improving the Patient Experience</i> Dept of Health 2003 – <i>Appendix 1, Children cared for in an environment equipped for their needs and by staff trained to meet those needs.</i></p> <p><i>National Service Framework for Long-term conditions</i>, Dept of Health 2004, <i>Quality Requirement 3 - emergency & acute management.</i></p> <p><i>National Standards, Local Action; Health & Social Care Standards & Planning Framework 2005-2008</i>, Dept of Health 2004. <i>Appendix 1: existing commitment – delayed transfer of care to be reduced to a minimal level by 2006</i></p>
<p>Paediatric Intensive Care Unit (PICU)</p>	<p>√ √</p>	<ul style="list-style-type: none"> > The PICU consultant discusses Jack's referral with the paediatric neurosurgeon at the specialist centre before his arrival. > At the tertiary centre Jack has a head CT scan and requires immediate surgery for an extradural haemorrhage. He remains unconscious for about one week and requires intensive life support. > A room is provided in the hospital, close to PICU, to enable his parents to be resident. Jack's parents have arranged for Jack's siblings to stay with relatives and visit hospital each day. > The paediatric neurosurgeon and PICU consultant discuss Jack's progress with his parents on a regular basis. They are made aware of the risks due to Jack's brain injury, and the uncertainty of outcome at this stage. They assure his parents that Jack's GP will be 'put in the picture' straight away and be regularly informed of his progress. 	<p>Standard 6 & 7 – specialist care available, as appropriate to the needs of young children</p> <p>Standard 2 – supporting and empowering parents to care for their children</p>	<p><i>Improving the Patient Experience</i>, Dept of Health 2003 – <i>Appendix 1, accommodation should be offered to parents of children in hospital and they should be encouraged to stay</i></p> <p><i>Headway, Brain Injury Assoc.</i> 4 King Edward Crt Nottingham NG1 1EW Tel: 0115.924.0800 www.headway.org.uk</p>

	Journey	Children's NSF Theme	Evidence/Links
<p>Paediatric Intensive Care Unit (PICU) (cont.)</p> <p style="text-align: center;">v v</p>	<ul style="list-style-type: none"> > Jack's 'named nurse' provides a focus for co-ordination of Jack's care in PICU. The nurses offer comfort and support to the family. In response to Jack's father's concerns about his job, the nurse suggests that he visits his GP to obtain a sick note. This will enable him to have leave from work to be with Jack in hospital. > Jack's parents are provided with written material about his condition and care, including information on relevant voluntary organisations and parent support groups. With their agreement, a link is made with a local voluntary organisation co-ordinator by the 'named nurse'. > Early intervention to accelerate Jack's rehabilitation is part of routine care. This includes assessment and input from a physiotherapist (eg chest) and speech therapist (eg swallowing reflex) and occupational therapist (eg identifying appropriate levels of sensory stimuli). > The hospital social worker visits Jack's parents and offers her practical support and assistance, promises to stay in touch and provides her contact details. She ensures that the parents have information on financial support for hospital visiting and for any childcare associated with visiting Jack. > The hospital chaplain visits Jack and his family to provide pastoral care and offers his future support. > Early support of parents in PICU is also provided by the paediatric clinical neuropsychologist. > Prior to leaving PICU, members of the rehabilitation team who will be involved in Jack's care when he is transferred to the paediatric ward come to meet the family. Their aim is to ensure a smooth transition and allay family anxieties about the process of transfer to a new environment and regime of care. 	<p>Standard 3 – information for parents and caring for children in the context of their family</p> <p>Standard 6, 7 & 8 – early intervention to aid recovery and rehabilitation</p> <p>Standard 3 – co-ordinated and holistic care for the child and his family</p> <p>Standard 3 – respect for children's and family's individuality and beliefs</p>	<p><i>Child Brain Injury Trust, The Radcliffe Infirmary, Woodstock Road Oxford, OX2 6HE Tel: 08456014939 www.cbituk.org/</i></p> <p><i>British Institute for Brain Injured Children Knowle Hall, Knowle, Bridgwater, Somerset TA7 8PJ Tel: 01278 684 060 Web: www.bibic.org.uk</i></p> <p><i>Contact-a-family Tel: 020 7608 8700 Helpline: 0808 808 3555 Email: info@cafamily.org.uk</i></p> <p><i>Emerging Findings, Dept of Health 2003, Ch 5, Disabled children and long-term conditions. Family-centred services that address all types of need.</i></p> <p><i>National Service Framework for Long-term conditions, Dept of Health 2004, Quality Requirement 4, early and specialist rehabilitation</i></p>

	Journey	Children's NSF Theme	Evidence/Links
<p>Transfer to Paediatric Ward √</p>	<ul style="list-style-type: none"> > When Jack has been weaned off life support and no longer needs intensive care, he is transferred from PICU to the high dependency unit for a short interim period before moving on to a paediatric ward at the same tertiary centre. > Here, his clinical and rehabilitation care is led by a paediatric neurologist, with a multi-disciplinary team of therapists who specialise in neurorehabilitation. > Jack still has POP to his left arm but the injuries to his hands and face have healed and the sutures have been removed. It is important not to delay the next stage in his rehabilitation, in order to ensure that the recovery of his abilities is maximised. 	<p>Standard 7 – hospital standard. Access to appropriate specialist care.</p> <p>Standard 8 – early intervention to prevent irretrievable loss of function and ability</p>	<p><i>House of Commons Select Committee on Health report Head Injury Rehabilitation 2001 – rehabilitation to start as soon as possible after medical stabilisation</i></p>
<p>Functional Ability Assessments √</p>	<ul style="list-style-type: none"> > A range of clinical assessments by the rehabilitation team is arranged to provide an overall picture of Jack's functional ability, to include:- occupational therapy, physiotherapy, audiology, optometry/orthoptist, speech & language therapy, paediatric clinical neuropsychology, hospital teaching service, play therapy, dietetics. > The assessment results show that Jack has sustained brain damage, which has affected:- co-ordination; fine movements; self-care skills; mobility & balance; hearing in left ear; vision (squint); speech (dysphasia); short term memory & attention; executive skills; behaviour. > With Jack's parents' agreement, relevant information about the assessment results is communicated to health, social and education colleagues in all sectors, which are (or anticipated to be) involved in his care. 	<p>Standard 8 – comprehensive disability assessment.</p> <p>Standard 1 – early intervention.</p>	<p><i>House of Commons Select Committee on Health report Head Injury Rehabilitation 2001 – people with suspected brain injury assessed by specialist staff and nursed in an appropriate location to their needs.</i></p> <p><i>Framework for the assessment of children in need and their families, DH & DfES, 2000 www.dh.gov.uk</i></p>

	Journey	Children's NSF Theme	Evidence/Links
<p>Case Review – Family Explanation & Discussion √</p>	<ul style="list-style-type: none"> > The results of Jack's assessments are the subject of a case review, attended by the multi-disciplinary/ multi-agency ABI rehabilitation team. Jack and his parents attend, although Jack can stay only so long as his tolerance/stamina allows at this stage. > At the case review, representatives from the rehabilitation team led by the paediatric neurologist answer the family's queries on the assessment results. They explain, in accordance with the 'Scope' good practice template, that the results indicate that Jack has some degree of acquired brain injury (ABI). They also explain that - > ABI is a disability for which symptoms will vary according to the site and severity of the injury to the brain. As ABI, in many cases, cannot be seen it is often known as a 'hidden disability' and can also have other causes, e.g. meningitis, encephalitis or after brain tumour and its powerful life-saving treatments. > Jack's excessive fatigue is a typical symptom post-ABI. > Although it is too early to say precisely what the long-term outcomes of Jack's ABI will be, there is good reason to expect significant improvement. A full rehabilitation programme, tailored to suit Jack's individual needs, will speed his progress. This will include all aspects of his well-being; involving health, social and educational input. > There are no long-term effects from Jack's other physical injuries. > Jack and his family are reminded of relevant contact details and also offered non-clinical support through, <ul style="list-style-type: none"> - the hospital paediatric social worker who, with the family's agreement, is named as Jack's key worker, - local support groups (reminder of contact details) - counsellor/mentor/advisor - support for emotional and bereavement needs (through local support group or neuropsychology service). 	<p>Standard 3 – information sharing and involving family in decisions.</p> <p>Standard 8 – co-operation between professionals, sharing information.</p> <p>Standard 8 – keeping parents fully informed and involved at each stage.</p> <p>Standard 2 – supporting parents.</p> <p>Standard 3 – holistic care in context of the whole family.</p> <p>Standard 8 – disabled child to be given key worker.</p>	<p><i>Right from the Start Template: good practice in sharing the news. 'Scope' & Dept of Health 2003</i></p> <p><i>National Standards, Local Action; Health & Social Care Standards & Planning Framework 2005-2008, Dept of Health 2004. Priority II - supporting people with long-term conditions; personalised care plans for vulnerable people most at risk. Fourth domain - patient focus, core standard 13; patients, relatives and carers treated with dignity and respect.</i></p>

	Journey	Children's NSF Theme	Evidence/Links
<p>Return Home √</p>	<ul style="list-style-type: none"> > Jack is taken home by his parents in the family car. > He takes the wheelchair with him, which the hospital OT has obtained on loan. > Jack's parents organise a sofa in the sitting room to provide him with a day bed, as required, and to facilitate more family inclusion. 	<p>Standard 3 and 8 – Child-centred care in family context.</p>	
<p>Rehabilitation and follow-up care √</p>	<ul style="list-style-type: none"> > In accordance with the hospital's discharge plan, Jack's GP, primary care, community, social services and education teams all receive the necessary information about Jack. This is planned to arrive at least one week before Jack's discharge, so that smooth hand-over can be organised, including delivery of equipment. > The local children's social worker visits the family and offers ongoing practical support. As Jack's key worker, she carries out an assessment of his and the family's wider needs. > The GP, who has received a full summary of Jack's hospital course, pays a home visit to assure himself that there are no outstanding concerns, which need his immediate action > The community matron (or school nurse) links with the key worker (social worker) and in addition provides a link between the family and the local health services. She assures Jack's family that she will keep the school up-to-date with his progress, ready for his later return to school. > The community speech and language therapist provides regular therapy for Jack. > The community physiotherapist visits and shows Jack and his parents how to manage the stairs safely and the exercises he can do to improve his balance. > The community OT also calls and checks how Jack is managing with self-care and the adapted equipment -and advises, as appropriate. She shows him activities to improve his functions and helps his siblings and friends to understand his needs to join in play. > LEA put in place an individual education plan for Jack, with immediate effect, which includes a home teacher. > Thus Jack continues his rehabilitation at home with input from his family, the primary care team, community therapists, school nursing service, LEA and supported by the neuro- and educational psychologists. 	<p>Standard 3 and 8 – Child-centred care in family context.</p> <p>Standard 8 - key worker to help family obtain services they need.</p> <p>Standard 2 – supporting parents.</p> <p>Standard 8 - specific information is provided to siblings of disabled children.</p>	<p>House of Commons Select Committee on Health Report, Head Injury Rehabilitation 2001 – co-ordination of services in the community.</p> <p><i>Supporting people with long-term conditions</i>, Dept of Health 2004, Ch 2 – case management; identify patients with complex conditions.</p> <p><i>Chief Nursing Officer's review of the nursing, midwifery & health visiting contribution to vulnerable children and young people</i>, Dept of Health 2004 – greater skill mix and more multi-disciplinary working.</p> <p><i>House of Commons Select Committee on Health Report, Head Injury Rehabilitation 2001</i> – identifiable guide and advocate through the whole care pathway.</p> <p><i>National Service Framework for Long-term conditions</i>, Dept of Health 2004, quality requirement 5 - community rehabilitation and support.</p> <p><i>Supporting people with long-term conditions</i>, Dept of Health 2004, Ch 2 – support to stay at home.</p>

	Journey	Children's NSF Theme	Evidence/Links
<p>Support for the Family</p> <p>∨</p>	<ul style="list-style-type: none"> > As a result of the social (key) worker's assessment, a number of actions are planned. Care will be provided on a case management basis. > Through their key worker, counselling is made available for Jack's parents and siblings, who are suffering great distress and anxiety at this time. > They are reminded of contact details for 'Contact-a-Family' for additional support. They are also reminded again of the contact details for specialist ABI voluntary organisations and given contact details 'Road Peace' which provides information, support and advice for people who have been affected by a road traffic accident. > The key worker (social worker) also provides advice about applying for benefits and assistance with filling in forms (eg. Disability Living Allowance, Carers Allowance, tax credits). She also provides information to the parents about Direct Payments, which can be used to provide flexible and individualised support. > Jack's parents are also given information on the Family Fund. Jack's mother needs to learn to drive because public transport is poor and inaccessible in her area. The Family Fund agrees to pay for driving lessons. > Jack receives visits at home from his school friends, organised by the class teacher, which helps maintain friendship and reduce social isolation. > Short-breaks are provided for Jack so that his parents can spend time with their other children and have respite from caring for Jack. > Jack is also offered a summer holiday with other ABI children, through an ABI charitable organisation, which is able to cater for their needs. He is delighted to take the opportunity. During his holiday Jack makes new friends who have ABI due to other causes. He notes that whilst they may need some different treatments, many of their rehabilitation needs are similar. They provide mutual support and encouragement and enjoy each others' company. > Jack's siblings are offered the opportunity to attend weekend break, by the same organisation. 	<p>Standard 2 – Supporting parents; providing information and involving parents in care.</p> <p>Standard 8 - key worker ensures access to services.</p> <p>Standard 8 – short breaks for children, young people, parents and carers provide positive experiences and reduces stress.</p>	<p><i>NHS Improvement Plan, Dept of Health 2004 - care of people with long-term conditions.</i></p> <p><i>Contact-a-family,</i> Tel: 020 7608 8700 Helpline: 0808 808 3555 Email: info@cafamily.org.uk</p> <p><i>Road Peace</i> Tel: 020.8838.5102 Helpling: 0845.4500.355 email: info@roadpeace.org</p> <p><i>Parents' Guide to Direct Payments – Council for Disabled Children 2004.</i></p> <p><i>Carers and Disabled Act 2000.</i></p> <p><i>Disability Discrimination Act 1995 – social inclusion of disabled people</i></p> <p><i>National Service Framework for Long-term conditions, Dept of Health 2004, quality requirement 10 - support for family and carers.</i></p>

	Journey	Children's NSF Theme	Evidence/Links
<p>Early provision of individual education needs</p> <p>∨</p>	<ul style="list-style-type: none"> > The LEA Hospital & Home Teaching Service make arrangements for an individual education plan, which includes a home teacher to visit Jack for short sessions 2-3 times a week, in the first instance. They explain to Jack's parents that the more detailed multi-disciplinary assessment (MDA) will be set up immediately by the LEA to ensure appropriate educational provision in the future. This involves gathering specialist reports (including hospital reports) to present to the MDA panel. > It also includes an early appointment for Jack to see an educational psychologist organised by the LEA, as requested in the paediatric clinical neuropsychologist's report. Close liaison between educational and clinical neuropsychologist is critical throughout the entire process. > The home teacher is able to provide assistance to help Jack regain confidence in his reading and writing skills, which were both affected by his injury. > The MDA Panel makes its assessment and grants Jack a Statement of Special Educational Needs. This assessment process is completed within 6 months 	<p>Standard 9 – partnership working for children with psychological and special educational needs.</p>	<p><i>Access to Education for children and young people with Medical needs. DfES, DH 2001</i></p> <p><i>National Service Framework for Long-term conditions, Dept of Health 2004, quality requirement 4 - access and re-access</i></p>
<p>Statement of Special Education Needs</p> <p>∨</p>	<ul style="list-style-type: none"> > Jack's Statement of Educational Needs makes a number of educational and non-educational provisions, which comply with the SEN code of practice. Copies of the Statement are given to the parents and to teaching centre. Provision includes - > Gradual phasing out of the home teaching and to start attendance at the teaching centre and a gradual re-introduction to his mainstream primary school, depending on progress with Jack's physical, social, psychological and behavioural rehabilitation, > Teaching assistant support in lessons and breaks, > Whilst at the teaching centre, provision to allow attendance for rehabilitation, as required. > Special equipment, as advised by health professionals > The Statement is reviewed annually (with interim reviews, if required) when the provision can be amended, according to his changing needs. 	<p>Standards 3 & 8 – Holistic care for children, which is flexible to their circumstances and needs.</p>	<p><i>Special Educational Needs (SEN) code of practice 2001</i> www.teachernet.gov.uk/teachinginengland/detail</p> <p><i>Access to Education for children and young people with Medical needs. DfES, DH 2001 – flexibility to changing needs.</i></p>

	Journey	Children's NSF Theme	Evidence/Links
<p>Injury prevention & Road Safety ↓</p>	<ul style="list-style-type: none"> > Following Jack's accident outside the school gates, the school reviewed the provision of safety training on offer to children and the wider injury prevention measures. > The head teacher sets up discussion between representatives from all interested parties. The views of pupils, parents, staff, police, school nurse, PCT/public health, local authority (LA) road safety division are sought. As a result, a number of actions are proposed - > additional sessions from the LA at the local safety centre, which provides road safety and other awareness training for pupils and staff. > review and revise the school's travel plan, to encourage more children to walk and cycle to school and to reduce traffic congestion. The school decides to increase provision of safe cycle storage, provide less hazardous pick-up and drop-off points for cars and to consider setting up 'walking buses'. > The LA reviews the road layout around the school, increases the parking restrictions at the school entrance and looks at further road safety design features around the school entrance, including employment of a crossing patrol officer. > The LA and PCT agree to provide and fund more cycle training for children to the new national standards, > The school obtained agreement to be linked to the National Cycle Network to facilitate safe cycling to school. 	<p>Standard 2 – supporting parents in achieving the best outcomes for their children.</p> <p>Standard 2 – good, high quality, timely support for parents as their children grow up is likely to improve outcomes for children and young people.</p> <p>Standard 1 – PCT and local authorities ensure that childhood injuries and accidents are reduced through development and monitoring of injury prevention strategies that target priority areas, where there are marked inequalities.</p>	<p>Dept for Transport PSA target – to reduce the number of children killed or seriously injured by 50% by 2010, compared to 1994-8 baseline, especially in disadvantaged communities.</p> <p><i>National Healthy Schools Programme to be promoted, especially in deprived communities, where number of childhood injuries is higher.</i></p> <p>World Health Organization (WHO) 5-year plan for road traffic injury prevention 2002 – support for interventions which focus on vulnerable road users.</p> <p><i>Choosing Health; making healthier choices easier, DH 2004, Ch 3 children and young people starting on the right path: - Active travel plan by 2010, - National Standard for Cycle training by 2006.</i></p>
<p>Secondary School ↓</p>	<ul style="list-style-type: none"> > Jack's statement is amended, naming his secondary school by 15th February in the year of transfer. > Visits to the new school are arranged in advance so Jack can familiarise himself with the new environment and staff. Education and school nursing staff from the 2 schools liaise to ensure that Jack's move from primary to secondary education is as smooth as possible. > In discussion with Jack and his parents, therapists and educational psychologist, the secondary school develop a new healthcare plan for Jack, building on the plan from his primary school. 	<p>Standard 3 & 8 – integrated, co-ordinated care, which are flexible to changing needs and circumstances.</p> <p>Standard 4 – respecting and involving young people in their care.</p>	<p><i>Supporting pupils with medical needs</i> DfES/DH 1996 – school to be aware of pupil's needs before he/she starts school and to develop written healthcare plan in consultation with pupil, parents & health professions.</p>

	Journey	Children's NSF Theme	Evidence/Links
<p>Transition to adult services</p> <p>∨</p>	<ul style="list-style-type: none"> > Jack's progress is reviewed on a regular basis with his paediatric neurologist and the rehabilitation team. This is important, particularly as Jack grows and develops because new difficulties may come to light as he becomes involved in new activities. > Fortunately for Jack, the specialist rehabilitation service is equipped and staffed to cater for both children and adults. At the age of 18 years, the paediatric consultant suggests that it may now be the right time to think about transfer of Jack's reviews to the adult team in the same centre. > Jack is assured that the process will be gradual, with opportunities to meet with members of both teams jointly, before formally transferring his care to the adult service. Jack is happy, feels he is ready for the transition and agrees to this arrangement. 	<p>Standard 4 – smooth transition to adult services.</p> <p>Standard 8 - integration and co-operation between partners.</p>	<p>NHS Improvement Plan 2004, Ch 3 – people with long-term conditions to have more control over their care and to have the right level of support, individually tailored to their needs.</p>



© Crown copyright 2004

For more information about the NSF go to:
<http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/fs/en>