

Transforming Children’s Community Services (TraCCS) Study

Cost questions for parent(s) interview

*To be administered by the researcher at the end of the **FIRST** interview. This questionnaire refers to resource use in the **6 month period immediately before** parents are allocated a Children’s Community Nursing Team.*

Your child’s use of hospital services:

1. Has your child had any overnight stays in hospital **during the past 6 months?**

Yes → If **yes**, please estimate the total number of nights:
No

2. Has your child had any outpatient appointments **during the past 6 months?**

Yes → If **yes**, please estimate the total number of attendances:
No

3. Has your child attended an Accident & Emergency department **during the past 6 months?**

Yes → If **yes**, please estimate the total number of attendances:
No

4. Has your child attended hospital for day case surgery **during the past 6 months?**

Yes → If **yes**, please estimate the total number of attendances:
No

5. Has your child attended hospital for other day case treatment **during the past 6 months?**

Yes → If **yes**, please estimate the total number of attendances:
No

Your child’s use of services outside the hospital:

6. Here is a list of other services your child may have been in contact with (use show card).

I will read each one out. Please tell me if your child has had contact with this service in the **past 6 months** and estimate the total number of contacts for each (please enter '0' if a particular service was not used):

General Practitioner	<input type="text"/>	<input type="text"/>	<input type="text"/>
Practice Nurse	<input type="text"/>	<input type="text"/>	<input type="text"/>
Occupational Therapist	<input type="text"/>	<input type="text"/>	<input type="text"/>
Speech and Language Therapist	<input type="text"/>	<input type="text"/>	<input type="text"/>
Physiotherapist	<input type="text"/>	<input type="text"/>	<input type="text"/>
Clinical or Child Psychologist	<input type="text"/>	<input type="text"/>	<input type="text"/>
Children's Social Worker	<input type="text"/>	<input type="text"/>	<input type="text"/>
Child Development Officer	<input type="text"/>	<input type="text"/>	<input type="text"/>
Health Visitor	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (please specify below):	<input type="text"/>	<input type="text"/>	<input type="text"/>

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Use of day services:

7. Has your child used any other services (e.g. home sitting, weekend clubs, home support) **during the past 6 months**? Please include any private or voluntary services:

Yes
 No

If **yes**, please state (if possible) the approximate number of times you attended:

<input type="text"/>	<input type="text"/>
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8. Has your child used any respite services (e.g. overnight or day residential stays for child/family, activity holidays) **during the past 6 months**? Please include any private or voluntary services:

Yes
 No

If **yes**, please state (if possible) the approximate number of times you attended:

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Other costs you might have to pay:

9. Have you or your partner made any other payments as a result of your child's condition: (e.g. adaptations to your home or specialist equipment)?

Yes
No

If **yes**, approximately how much have you had to pay **during the last 6 months?**

£

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Employment (parent being interviewed):

10. a) Are you currently in paid work?

Yes → If **yes**, go to Q11
No

b) If **no**, over the **last 6 months**, were you in paid employment?

Yes → If **yes**, go to Q11.
No → If **no**, go to Q13.

11. How many hours or days did/do you work on average per week?

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Hours/Days (delete as appropriate)

12. Have you taken any days off from work **over the preceding 6 months specifically to deal with your child's illness?**

Yes → If **yes**, please estimate the number of days:

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No

Employment (Partner of parent being interviewed, if applicable):

13. a) Is your partner currently in paid work?

Yes → If **yes**, go to Q14.
No

b) If **no**, over the **last 6 months**, was your partner in paid employment?

Yes → If **yes**, go to Q14.
No → If **no**, go to end of cost questions.

14. How many hours or days did/do your partner work on average per week?

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Hours/Days (*delete as appropriate*)

15. Has your partner taken any days off from work **over the preceding 6 months specifically to deal with your child's illness?**

Yes
No

→ If **yes**, please estimate the number of days:

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END OF COST QUESTIONS & INTERVIEW

Transforming Children's Community Services (TraCCS) Study

Cost questions for parent(s) interview

To be administered by the researcher at the end of the **SECOND** interview. This questionnaire refers to resource use in the **previous 6 month period**.

Your child's use of hospital services:

1. Has your child had any overnight stays in hospital **during the past 6 months?**

Yes → If **yes**, please estimate the total number of nights:

No

2. Has your child had any outpatient appointments **during the past 6 months?**

Yes → If **yes**, please estimate the total number of attendances:

No

3. Has your child attended an Accident & Emergency department **during the past 6 months?**

Yes → If **yes**, please estimate the total number of attendances:

No

4. Has your child attended hospital for day case surgery **during the past 6 months?**

Yes → If **yes**, please estimate the total number of attendances:

No

5. Has your child attended hospital for other day case treatment **during the past 6 months?**

Yes → If **yes**, please estimate the total number of attendances:

No

Your child's use of services outside the hospital:

6. Here is a list of other services your child may have been in contact with (*use show card*).

I will read each one out. Please tell me if your child has had contact with this service in the **past 6 months** and estimate the total number of contacts for each (please enter '0' if a particular service was not used):

General Practitioner	<input type="text"/>	<input type="text"/>	<input type="text"/>
Practice Nurse	<input type="text"/>	<input type="text"/>	<input type="text"/>
Occupational Therapist	<input type="text"/>	<input type="text"/>	<input type="text"/>
Speech and Language Therapist	<input type="text"/>	<input type="text"/>	<input type="text"/>
Physiotherapist	<input type="text"/>	<input type="text"/>	<input type="text"/>
Clinical or Child Psychologist	<input type="text"/>	<input type="text"/>	<input type="text"/>
Children's Social Worker	<input type="text"/>	<input type="text"/>	<input type="text"/>
Child Development Officer	<input type="text"/>	<input type="text"/>	<input type="text"/>
Health Visitor	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (please specify below):	<input type="text"/>	<input type="text"/>	<input type="text"/>

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Use of day services:

7. Has your child used any other services (e.g. home sitting, weekend clubs, home support) **during the past 6 months**? Please include any private or voluntary services:

Yes
No

If **yes**, please state (if possible) the approximate number of times you attended:

<input type="text"/>	<input type="text"/>
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8. Has your child used any respite services (e.g. overnight or day residential stays for child/family, activity holidays) **during the past 6 months**? Please include any private or voluntary services:

Yes
No

If **yes**, please state (if possible) the approximate number of times you attended:

<input type="text"/>	<input type="text"/>
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Other costs you might have to pay:

9. Have you or your partner made any other payments as a result of your child's condition: (e.g. adaptations to your home or specialist equipment)?

Yes

No

If **yes**, approximately how much have you had to pay **during the last 6 months?**

£

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Employment (parent being interviewed):

10. a) Are you currently in paid work?

Yes → If **yes**, go to **Q11**.

No

b) If **no**, over the **last 6 months**, were you in paid employment?

Yes → If **yes**, go to **Q11**.

No → If **no**, go to **Q13**.

11. How many hours or days did/do you work on average per week?

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Hours/Days (delete as appropriate)

12. Have you taken any days off from work **over the preceding 6 months specifically to deal with your child's illness?**

Yes → If **yes**, please estimate the number of days:

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No

Employment (partner of parent being interviewed, if applicable):

13. a) Is your partner currently in paid work?

Yes → If **yes**, go to **Q14**.

No

b) If **no**, over the **last 6 months**, was your partner in paid employment?

Yes → If **yes**, go to **Q14**.

No → If **no**, go to **Q16**.

14. How many hours or days did/do your partner work on average per week?

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Hours/Days (delete as appropriate)

15. Has your partner taken any days off from work **over the preceding 6 months specifically to deal with your child's illness?**

Yes → If **yes**, please estimate the number of days:
No

16. Has the involvement of the CCN team changed the amount of time you spend **caring for your child's condition/health?** (*use show card*):

I have spent less time caring for my child

Has not had an effect

I have spent a little more time caring for my child

I have spent a lot more time caring for my child

→ If a change, follow-up with: Has that, in turn, had any impact on you or your family?

17. Has the involvement of the CCN team changed the amount of time you spend on **enjoyable activities with your child?** (*use show card*):

I have spent less time on enjoyable activities with my child

Has not had an effect

I have spent a little more time on enjoyable activities with my child

I have spent a lot more time on enjoyable activities with my child

→ If a change, follow-up with: Has that, in turn, had any impact on you or your family?

END OF COST QUESTIONS & INTERVIEW