**Children and Young People's Continuing Care Policy**

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| **KEY POLICY MESSAGES** |
| 1. Sets out the principles for joint operational management of Children and Young People’s Continuing Care between NHS Derby and Derbyshire Integrated Care Board and Derby City Council and Derbyshire County Council. |
| 1. Sets out the principles for the operational management of children and young people who have complex health needs for who NHS Derby and Derbyshire ICB are responsible for. |
| 1. Aims to assess the complex health needs of a child or young person equitably and fairly, providing the appropriate relevant support so that parents may continue caring for their child with complex health needs. |

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1. Policy Development process

This policy sets out the principles for joint operational management of Children and Young People’s Continuing Care between NHS Derby and Derbyshire Integrated Care Board ("ICB"), Derby City Council and Derbyshire County Council.

1. Abbreviations

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| --- | --- |
| CC | Continuing Care |
| DST | Decision Support Tool |
| NA | Nurse Assessor |
| ICB | Integrated Care Board |
| LA | Local Authority |
| MLCSU | Midlands and Lancashire Commissioning Support Unit |
| MDT | Multi-Disciplinary Team |
| EOL | End of Life |
| LAC | Looked After Child |
| SEND | Special Educational Needs and Disabilities |
| EHCP | Education Health Care Plan |
| CHC | Continuing Health Care |
| ICP | Individual Care Plan |
| PHB | Personal Health Budget |
| MCA | Mental Capacity Act |
| LD | Learning Disability |
| DOLS | Depravation of Liberty Standards |
| CAMHS | Child and Adolescent Mental Health Service |

* 1. The following should be considered when reading the policy:
     1. Parent/s, Carers, Foster Carers and Family will be known as 'Parents' for the purpose of this policy;
     2. the transition phase and period from around 14 years to the 18th birthday will be identified as transition. It is recognised that this is a time where the young person is moving through a period of transition and is preparing for adulthood;
     3. the term 'Nurse Assessor' will be used to describe the roles of the Nurse Assessors and Case Managers within Midlands and Lancashire Commissioning Support Unit (MLCSU);
     4. the term 'residential placement' should be read to include residential and educational placement;
     5. any reference to the Local Authority will be inclusive of social care and education, unless otherwise stated;
     6. the term 'health needs' will be used to reference physical health, mental health, learning disability and end of life needs; and
     7. Transforming Care (Building the Right Support), Section 117 Aftercare, and treatment/therapies are referred to within this policy although these would not require assessment under Continuing Care remit, separate processes are utilised.

1. Equality Statement
   1. The general equality duty requires public authorities, such as the ICB to have due regard to the aims of the general equality duty when making decisions and setting policies. To do this, it is necessary for the organisation to understand the potential impact of its decision making on different people. This can help to identify practical steps to tackle any negative impacts or discrimination, and to advance equality.
   2. The ICB endeavours to challenge discrimination, promote equality and respect human rights and aims to design and implement policies, services and measures that meet the diverse needs of our population, patients, and workforce, ensuring that non are placed at a disadvantage.
2. Equality Analysis
   1. The ICB undertakes an Equality Analysis of policies, strategies, service design and other relevant activities to assess the impact of decision making against:
      1. the nine protected characteristics (age, disability, ethnic origin, sex, sexual orientation, gender reassignment, religion and belief, marriage, or civil partnership, or maternity status);
      2. other groups or communities known to suffer disadvantage, such as the homeless, carers, migrants and sex workers;
      3. human rights; and
      4. known health inequalities.
   2. This analysis also explores the potential to support the Social Value Act.
3. Executive Summary
   1. This policy sets out the principles for the operational management of children and young people who have complex health needs for who the ICB are responsible for. MLCSU will act on behalf of the ICB and will carry out the necessary processes in relation to those child and young people who fall within the remit of NHS Continuing Care.
   2. MLCSU will work jointly with the Local Authorities (LA) who are Derby City Council and Derbyshire County Council, (which is inclusive of social care and education), to understand and manage those child and young people who have a complex health need and require a package of health support irrespective of setting, and who fall within the remit of NHS Continuing process.
   3. Continuing Care is a nationally recognised term that is described within the Children and Young People’s National Framework (2016) as a package of care that is individually tailored to meet a child and young person’s complex health needs, defined through a robust assessment process as *"arising as a result of a disability, accident or illness that cannot be met by existing universal or specialist services alone"* (National Framework for Children and Young People’s Continuing Care 2016).
   4. This policy applies to those children and young people aged between 0–17 years who may have one or a combination of the following needs:
      1. physical disability;
      2. mental health;
      3. learning disability; and/or
      4. end of life.
   5. Whilst a child or young person may be identified as having complex health needs, it is important to understand that for the majority, and predominantly they may have a combination of health, education and social care needs, that require multi-agency collaboration and close working to jointly assess, manage and provide the support needed.
   6. The policy will demonstrate how the local ICB, and LA’s will work together to support children and young people through to adulthood with complex health needs, utilising the National Framework for Children and Young People’ Continuing Care (2016) as guidance.
   7. This policy has been developed to ensure the child and young person is at the centre of decision-making, and who are supported through their journey into adulthood to improve outcomes. This commitment requires continued multi-agency involvement and a joint working approach to understand the needs of children and young people; first and foremost. Joint decisions are made through a multi-agency approach via a multi-agency panel infrastructure.
   8. The policy shows how the ICB and LA’s will combine the Education Health Care Plan (EHCP) and Continuing Care processes (where applicable), and where a child or young person has a special educational need or disability (SEND) the ICB and LA will jointly endeavour to coordinate the assessment and agree the package of Continuing Care, as part of the process to develop the child’s Education, Health and Care Plan.
   9. *"Where a child or young person has a special educational need or disability (SEND), the ICB’s and LA’s should jointly endeavour to coordinate the assessment and agreement of the package of Continuing Care, as part of the process to develop the child’s Education, Health and Care Plan"* ([National Framework for Children and Young People’s Continuing Care 2016](https://www.gov.uk/government/publications/children-and-young-peoples-continuing-care-national-framework)).
   10. The policy has been developed through multi-agency agreement and demonstrates how child and young people with complex needs requiring a bespoke package of support, can expect local agencies working together to provide support through a structured, equitable and transparent process. Each partner organisation will support a child or young person with complex needs according to individual and joint assessment, and in line with their statutory functions.
   11. Children and young people with complex health needs living at home with their parents will generally have their care mainly provided by them and is recognised that some parents may require help and support via a package of care within the home setting (or other suitable environment). The policy will show how multi-agencies will work together with parents and families enabling them to continue looking after and caring for their child.
   12. MLCSU acting on behalf of the ICB will take direction from the ICB in relation to local agreements and arrangements made between the LAs and the ICB. They will act in accordance with national and local guidance, legislation, and clinical governance requirements to provide assurances of safe healthcare delivery through care package procurement and commissioning process.
4. Introduction and background to policy development
   1. The purpose of this policy is to ensure that there is a consistent approach across partner agencies to ensure quality, equality and transparency in the assessment and agreement of eligibility for children and young people with complex health needs relating to NHS Continuing Care.
   2. The partner agencies involved in developing this policy and associated local joint processes, have a common understanding that a child or young person’s health, wellbeing and individual needs will be central to decision-making, and that partners will work together in a transparent and collaborative way to provide seamless provision.
   3. The National Framework for Continuing Care was first published by the Department of Health in March 2010. This was superseded by the [National Framework for Children and Young People’s Continuing Care](https://www.gov.uk/government/publications/children-and-young-peoples-continuing-care-national-framework) in 2016. The revised framework addressed changes to the NHS commissioning arrangements that resulted from the Health and Social Care Act (2012) and the integrated approach to commissioning services for children and young people with SEND arising from the Children and Families Act (2014).
   4. This policy must be read in conjunction with the National Framework, localised joint working arrangements and relevant legislation mentioned forthwith, when assessing the needs of child and young person whose complex needs cannot be met through existing universal or specialist services[: National Framework for Children and Young People’s Continuing Care](https://www.gov.uk/government/publications/children-and-young-peoples-continuing-care-national-framework).
   5. NHS Continuing Care provision is designed to support child and young person with complex health needs, to lead as fulfilling a life as possible, irrespective of the setting they are in. The ICB and LAs agree that collaborative support may be required from them to, but in doing it should not remove the parenting responsibility (unless circumstances determine otherwise). Otherwise, parents should remain responsible, and any support provided should enable them to continue looking after and caring for their child where appropriate.
   6. The SEND code of practice: 0 to 25 years, arising from the Children and Families Act 2014 define the use of a pivotal EHCP which will be integral to the NHS Continuing Care process. Complex health support requirements for child and young person eligible for CC elements in education will be considered via the assessment of needs in line with guidance.
   7. Decision making regarding eligibility will be guided by the Children and Young People’s Continuing Care National Framework (DOH, 2016) which suggests a system to understand levels of needs. However, clinical judgment is equally important and governed by demonstrating a clear reasoned evidenced base from a range of sources that takes account of the child and young person‘s particular health needs in a holistic and family centred context and embrace the principles of personalisation. In each area of the assessment, it should also be clear whether needs are met or unmet and based on current needs not past or future anticipated needs.
5. Purpose of the Policy

This policy aims to:

* 1. describe the local Continuing Care process, locally agreed arrangements and interpretation of the National Framework for Social Care, Health and Education partners (and other relevant stakeholders);
  2. ensure a fair and equitable approach is applied to all children and young people with complex health needs who are eligible for Continuing Care;
  3. ensure a joint, transparent, and consistent approach to assessing and responding to the relevant needs within EHCP’s;
  4. clarify the role and responsibilities within the Continuing Care process;
  5. equip local practitioners/professionals with the knowledge and tools to follow and support the process;
  6. clarify the remit and responsibilities of the partners involved in the Continuing Care process including processes for appeals and complaints raised by children, young people families, and inter-agency disputes;
  7. clarify local funding arrangements;
  8. clarify the local approach to commissioning;
  9. clarify local arrangements and processes for transitioning children and young people with continuing care needs to adult services; and
  10. describe the local approach to Personal Health Budgets (PHB’s).

1. Parental Responsibility
   1. The ICB and LA,s take the view that parents are the experts in the care of their child and have primary responsibility for their health, wellbeing and care, and will take an active part in caring for their child unless circumstances regarding parenting provision preclude them from providing a reasonable level of care. This will be balanced with the social care assessed need, especially where the Local Authority may have shared or corporate parenting responsibilities or have assessed the parents as requiring additional support.
   2. The first edition of the National Framework for Children and Young People’s Continuing care, published in 2010, addressed the point, describing:

*"Generally, parents, as experts in their child or young person’s care and as primary carers, provide the majority of care to the child or young person"* National Framework for Children and Young People (2010),

adding that:

*"Most care for children and young people is provided by families at home, and maintaining relationships between the child or young person, their family and other carers, is a particularly important aspect"* National Framework for Children and Young People (2010).

* 1. This policy aims to assess the complex health needs of a child or young person equitably and fairly, providing the appropriate relevant support so that parents may continue caring for their child with complex health needs.
  2. All agencies involved must work together to communicate and inform parents of all processes clearly, giving parents a consistent message of what they can expect from a package of care support from Continuing Care and a multi-agency approach to joint provision of support through a holistic assessment. Messages of information regarding CC should be available via the Local Offer ([see Appendix 9](#Appendix)) and ICB website, alongside locally developed CC leaflets providing an overview of the CC process ([see Appendix 7](#Appendix)).

1. NHS Continuing Care
   1. The Children and Young People’s National Framework describes that NHS Continuing Care is different for children as opposed to adults and advises that:

*"Continuing Health Care (CHC) for adults is governed by the* [*National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (2019)*](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/746063/20181001_National_Framework_for_CHC_and_FNC_-_October_2018_Revised.pdf)*. That framework gives guidance on putting in place complete packages of care where an adult has been assessed as having a primary health need. It means that the provision of all their resulting care needs, whether at home or in a care home, is the responsibility of the NHS"* ([National Framework for Children and Young People’s Continuing Care 2016](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/746063/20181001_National_Framework_for_CHC_and_FNC_-_October_2018_Revised.pdf)).

* 1. Children and Young People’s Continuing Care is defined within the National Children’s Framework as:

*"A continuing care package that will be required when a child or young person has needs arising from disability, accident or illness that cannot be met by existing universal or specialist services alone (section 1). and unless there is a good reason for this not to happen, continuing care should be part of a wider package of care, agreed and delivered by collaboration between health, education, and social care’"* ([National Framework for Children and Young People’s Continuing Care 2016](https://www.gov.uk/government/publications/children-and-young-peoples-continuing-care-national-framework)).

* 1. The framework recognises complex health needs in a child or young person, and that these sometimes cannot be met by the services which are routinely available in the community, in hospitals, general practices, commissioned by ICBs or National Health Service England/Improvement (NHSE/I). Continuing Care has come to describe the additional health support that may be required and is the responsibility of ICB to determine what and how they provide this according to assessed health need. Therefore, Derby and Derbyshire through local policy arrangement will work together as agencies to provide a supportive package of care, which meets a child or young person’s assessed needs cohesively.
  2. The National Frameworks’ inherent assessment and review process will be utilised in respect of any child and young person within the remit of Continuing Care. For the purpose of this policy the term Continuing Care, referring to NHS Continuing Care for Children and Young People (National Framework 2016).
  3. Local offers of support will be provided by each agency involved, derived from either standalone assessments or combined assessments (where possible). The joint local offer of support will be described to parents, child or young person after assessment/s have been performed, and wherever possible the support will be combined by multi-agencies to provide seamless provision. The support can be provided in a variety of settings i.e. at home, in respite facility, education setting, residential setting and does not need to be provided exclusively across all settings where the child and young person accesses i.e. the child and young person can be in receipt of support in an educational setting but not at home. It is additionally recognised that some parents do not want care at home.
  4. The National framework further delineates the special nature of childhood and youth and the importance of recognising the context in which they live their lives: ‘Childhood and youth is a period of rapidly changing physical, intellectual and emotional maturation alongside social and educational development. All children of compulsory school age (5 to 16) should receive suitable education, either by regular attendance at school or through other arrangements. There may also be social care needs. Most care for children and young people is provided by families at home, and maintaining relationships between the child or young person, their family and other carers, and professionals, is a particularly important aspect’
  5. Where a child and young person has a special educational need and disability, the ICB and local authorities should coordinate the assessment and agreement of the support provided via Continuing Care, as part of the process to develop the child’s EHCP. Whilst a child and young person may be identified as having continuing care health needs, it is important to understand that predominantly (and for the majority) those child and young person will have joint health, education and social care needs, that require joint arrangement and management where appropriate.
  6. The implication for and expectations of health and local government services is made clear in the Framework:

*"Children and young people’s continuing care needs are best addressed holistically by all the agencies that are involved in providing them with public services or care: predominantly health, social care and education. It is likely that a continuing care package will include a range of services commissioned by, ICB’s, Local Authority children’s services and sometimes others"* ([National Framework for Children and Young People’s Continuing Care 2016](https://www.gov.uk/government/publications/children-and-young-peoples-continuing-care-national-framework)).

* 1. The Framework describes that the CC process does not cover those child and young person whose needs can be met through existing universal and specialist services/resources and moreover should not in any way dilute the responsibilities of any individual agency from delivering a quality service in accordance with the statutory requirements of their role.
  2. In accordance with the National Framework an ICB is responsible for leading the commissioning of CC services. However, in recognising that a child and young person may require services from all agencies, the framework describes that there should be coordinated health, social care and educational assessments and that funding may be shared across partners in line with the needs of the child and young person.
  3. The revisions to the 2016 framework provide guidance regarding roles and responsibilities of the multi-disciplinary team (MDT), transition to adult services, (PHB’s and the integration required between CC and the Education in respect of the EHCP.
  4. Continuing Care for children and young people applies from birth to 17 years of age. From the age of 18 the adult Framework for NHS Continuing Healthcare and Nursing Funded Care Framework (2012) is applied; and separate criterion used to determine eligibility. The frameworks differ from each other, reflecting the requirement of multi-agency involvement within the child and young person Framework, parental involvement in care provision and specific contexts relating to the differing, and developing needs of children than to those in adulthood.
  5. The children’s framework requires decisions to be based on the assessed need of the child and young person following a holistic health needs assessment (HNA); in the first instance it requires all universal and commissioned NHS services to provide support in line with assessed need and within the remit the service specification. The framework does not give guidance on the amount or type of support that is required, nor on the arrangement of funding for individual packages of care; this is an individual arrangement on a case-by-case basis. The Framework guidance devolves these arrangements and agreements to local ICB’s and Authorities to locally determine joint working arrangements in relation to the type and amount of support for the child and young person based upon recommendations made by the MDT, parents, and CC Nurse Assessor. The appendices to this document will describe the local arrangements for Derby and Derbyshire.
  6. Since April 2014, every child and young person in receipt of CC, or their parents, have a right to ask for a PHB including a direct payment to manage this including with adequate brokerage support. This policy and the associated localised process will aim to address and capture the elements required to provide a PHB. The agencies (social care, education, and health) will co-ordinate care package arrangements to provide a model of flexibility and choice for parents, the child and young person via a PHB.
  7. The formalisation of local joint policy will ensure that the LAs' (education and social care), healthcare practitioners and other relevant professionals/non-professionals understand how and when to complete a checklist for a child and young person with complex health needs, as well as the process thereafter ([see Appendix 5](#Appendix)). The policy will provide details of the local joint working arrangements (within appendices) i.e. disputes and appeals process, step down provision from hospital to home, integration between CC and EHCP process, arrangements for LAC entering placements and subsequent funding arrangements (list is not exhaustive).
  8. Parental involvement is integral and is an important focus in the process, and wherever possible the child and young person should be involved; and in all instances must be given the opportunity to provide their views and preferences, (this area corresponding to section A of the EHCP). The policy and associated local working arrangement will address parental expectations and the local offer made by Health and the LA to meet the assessed needs of the child and young person eligible for NHS Continuing Care. In the case of shared parental responsibility, the LA will have a role in determining the child and young person’s care and support ([see Appendix 9](#Appendix)).
  9. Partner agencies have agreed that the Continuing Care Assessment (CCA) will be utilised in the first instance to determine the health needs of a child and young person if it is identified that there are unmet health needs which require a commissioned bespoke package of support or specific health intervention, MLCSU Continuing Care Children’s Service in conjunction with partner agencies will arrange and manage this. This includes bespoke packages of care irrespective of the setting and includes
     1. Physical disability (PD)
     2. Learning disability (LD)
     3. Mental health (MH)
     4. End of life care (EOL)

1. Section 117 aftercare, Transforming Care (Building the Right Support) and Treatment / Therapeutic Requirements
   1. **Section 117 Aftercare**
      1. Where a child and young person has Section 117 aftercare needs and also other complex health needs (LD, PD and EOL), the process outlined in this policy should be utilised to understand those ‘other complex health needs’ and how these and the child or young person’s health needs impact on each other. The statutory process relating to Section 117 Aftercare, and the assessment needs relating to NHS Continuing Care, will more than likely interrelate and should reference each other to determine the overall requirement of support and provision.
      2. The care and support identified for a child or young person within the remit of Section 117 Aftercare will take precedence and should dovetail within a required CCA and any subsequent care package, (referring to health needs not managed within the remit of Section 117 Aftercare). Both processes should work together to ensure seamless provision.
   2. **Transforming Care (Building the Right Support)**
      1. The process outlined within this policy will apply to children and young people who have needs and require support in relation to learning disability and/or autism who display behaviour that challenges, and also includes those with a mental health condition.
      2. The Continuing Care Service will apply the processes outlined in accordance with their commissioned remit in relation to Section 117 and Transforming Care or will signpost to the relevant persons responsible to manage process.
   3. **Treatments and Therapies**

The policy additionally recognises those cases where a child or young person requires treatment and therapies. In these instances, a proforma will be required to understand what needs a child or young person has, providing the rationale and provision of treatment required.

1. Leadership and accountability for NHS Continuing Care Process
   1. The ICB have a responsibility for assessing and commissioning, the reasonable healthcare requirements of an individual. The National Framework (2016) guidance describes the process which should be followed for the equitable discharge of that responsibility for child and young person with ‘very’ complex needs.
   2. It has been agreed that the partner agencies involved in this policy development will work together to provide joint care package arrangements, adhering to the principle of securing the best outcomes for both the child and young person and their family; with each organisation remaining responsible for its’ own statutory duties.
   3. The policy has been developed between senior representatives from Derby City Council, Derbyshire County Council, the ICB and MLCSU. Ratification of the policy will occur at Joined Up Care Derbyshire Board.
   4. The ICB is responsible for agreeing and managing appropriate governance arrangements and remains overall accountable in relation to NHS Continuing Care, which they delegate responsibility to MLCSU in carrying out the functions of the process on their behalf.
   5. The Continuing Care Children’s Service is part of MLCSU. It acts as the nominated Children and Young People’s Nurse Assessors and Case Managers for Continuing Care for the ICB, ensuring effective management and liaison with local authorities (education and social care), other stakeholders, and with families, children, and young people. The service co‑ordinates the Continuing Care process.
   6. Their work includes:
      1. coordinating and delivering multi-agency training relating to NHS Continuing Care process;
      2. coordinating and leading on the Continuing Care Assessment (CCA) process, following receipt of a checklist, progressed through to CCA ([see Continuing Care Assessment](#ContinuingCare)) CCA;
      3. quality assurance of checklist and Decision Support Tool (DST) completion ([see Appendix 4](#Appendix));
      4. liaison with the child, young person and parents to ensure that their views and preferences are listened to, understood and considered, including understanding ‘what life is like for them’ ([see Continuing Care Assessment](#ContinuingCare));
      5. understanding and working with the implications of consent to participate and considerations regarding principles within the Mental Capacity Act (MCA) relating to capacity, best interest, least restrictive, and ability and support in decision-making regarding the Continuing Care process;
      6. liaison with multi-agencies, third party organisations, acute community sector and attendance at relevant MDT meetings in relation to NHS Continuing Care;
      7. presenting individual cases, (including the recommendations) to the Continuing Care Panel; with regards to care package provision or provision via contribution, ([see Decision Making](#DecisionMaking));
      8. clinical commissioning case management;
      9. commissioning bespoke packages of healthcare for a child or young person, reporting back to the Continuing Care panel in the event of delay or difficulty in arranging and/or commencing care ([see Decision Making](#DecisionMaking));
      10. providing assurances of clinical governance is evident, and appropriate, in relation to the delivery of safe and appropriate care package provision ([see Arrangement of Provision](#Arrangementofprovision));
      11. completing the three-month review and managing subsequent reviews held annually, or when a change in need has been identified ([see Reviews](#Reviews));
      12. supporting transition of the young person into adulthood, working alongside the young person, parents and multi-agencies (child and adult services) ([see Decision Making](#DecisionMaking));
      13. manage appeals from a child, young person and/or their parents;
      14. manage inter-agency disputes, following the locally agreed guidance;
      15. co-ordinate and arrange Continuing Care meetings and generate relevant correspondence to members of the multi-disciplinary team (MDT), parents, child, young person, referrer, General Practitioner, and other relevant parties;
      16. ensure joint arrangements between the ICB, Las and stakeholders are adhered to;
      17. liaison with social workers, Looked After Children’s (LAC) Nurses, Independent Reviewing Officer, and placement staff, in relation to children who are Looked After;
      18. support and assist in signposting to the appropriate specialist leads who may assist in commissioning healthcare for LAC;
      19. ensure LAC in placement have the appropriate health, behavioural etc. assessments performed. The Continuing Care Assessment document may be utilised to capture all needs. This is to ensure children and young people are in receipt of safe and appropriate care whilst in residential placement/foster care arrangement; and
      20. keep and maintain records for data and reporting purposes. Sharing in accordance with data sharing agreements.
   7. The Children’s Continuing Care service is the point of contact, for multi-agency partners to liaise with when wanting to discuss a child or young person with possible Continuing Care requirements. The Continuing Care Children’s Service acts as the local ICB’s nominated child and young person health assessors and coordinates the process, ensuring effective management and liaison with LA’s and other partners and stakeholders in accordance with the National Framework (2016) and this policy. The service will liaise closely with the local ICB Designated Clinical Officers (DCO) for SEND working jointly with Derby and Derbyshire Councils’ (education and social care), to ensure the child and young person with complex health needs has a safe and comprehensive package of health support across health, education and social care settings.
2. Process Outline and Pathway

|  |  |  |  |
| --- | --- | --- | --- |
| **Phase** | **Stop** | **Summary of Key Actions** | **Timescale** |
| **Pre-Assessment and Assessment** | Identify | * MDT review a child or young person with complex health needs   **Pre-Assessment performed and Checklist completed**   * A child or young person with a potential Continuing Care is referred to the Continuing Care team * The 6-week clock starts from receipt of checklist into Continuing Care * Child and young person Nurse Assessor begins the process to arrange and complete a CCA | **24/48** hours to complete checklist and send to Children’s Continuing Care Team  Clock starts  **6 weeks** to commencing arrangement of provision |
| Assess | The health assessor undertakes the assessment, comprising:   * preferences of child or young person and their family; * holistic assessment of need; * reports from multi-disciplinary team; and * Decision Support Tool for child and young person. |
| Recommend | The health assessor completes the process of assessment and makes recommendations in relation to provision required for unmet health needs. |
| **Decision-making** | Decide | * The multi-agency panel considers the recommendation and ratifies the Nurse Assessor recommendations in relation to the continuing care process * If inter-agency dispute occurs at this stage as a result of disagreement, follow dispute process |
| **Arrangement of provision** | Inform | * The child and young person and their parents are informed of the decision. * Development of costed package of care. Any relevant organisations, such as the Local Authority, and key health professionals involved in the child and young person, s care (e.g., GP, paediatrician) should also be notified |  |
| Deliver | * Commissioning of the package of care and its provision to the child and young person. * Ongoing monitoring/contract management for the commissioned service |
| **Ongoing** | Review | * Review and reassessment of the child and young person’s health needs |

* 1. The Continuing Care process begins locally when there is recognition that a child or young person may have needs that require additional health support that cannot be met by existing universal, targeted and specialist services. The process has four phases:
     1. Assessment

Consisting of completion of a DST, preferences of child/young person and family, reports and risk assessments and holistic assessment.

* + 1. Decision-Making

Multi-agency forum or panel.

* + 1. Arrangement of Provision

Procurement of a bespoke care package, PHB arrangement, or confirmation that all health needs are being met in those child and young person cases where they have been placed in a care setting by LA prior to assessment being undertaken.

* + 1. Ongoing (Reviews)

At three months after initial set up, annually and as required if health needs alter ([see Appendix 4](#Appendix)).

* 1. Recognition of unmet health needs should be identified within a multi-disciplinary team meeting between health, social care and education professionals. It is important that partner agencies such as education and social care will need to be integral to discussions to perform a holistic assessment. Use of advocacy services must be considered, where necessary.
  2. Children and young people placed in residential and other settings are included and will have their complex health needs assessed, using the outlined process within this policy.
  3. Consent will need to be gained from the child, young person, and their parents (where necessary), and/or the LA (where co-parenting is in place). Consent to participate will be recorded, and considerations given to the capacity of a child and young person. Capacity and Depravation of Liberty Safeguards (DoLS) of an individual will need to be understood in accordance with the Mental Capacity Act (MCA (2005). The Children’ Service will make reasonable adjustments to enable participation through the process of Continuing Care. Where necessary an advocate will be requested to help support the child, young person, and if required the parents through the process. The consent form will capture the necessary information required.
  4. **Pre-Assessment/Completion of the Checklist and Continuing Care Assessment** 
     1. The MDT, parents and child or young person (where feasible) should meet to discuss what complex health needs are evident, and how these are impacting on the child/young person, and additionally what can be done to reduce the impact of health needs or reduce the risks identified. The MDT should review and gain understanding of what support is in place from health services, other agencies and family members.
     2. The MDT discussion should describe **what health needs are being met by** local NHS commissioned services (universal and specialist) and in an attempt to help resolve or reduce the needs the MDT need to explore the following in an attempt to reduce impact, and help the parents in caring for their child’s needs:
        1. amend or alter their support;
        2. amend, alter or provide new treatments through a review of health with a health care professional; and
        3. further refer to other services for assessment (to determine if other types of input can help reduce the amount of needs).
     3. Children and young people in residential settings will require the MDT to explore the availability of the local NHS services, to review, assess and manage health needs as they emerge.
     4. If the MDT agree that all available health services have been accessed and pursued, and the complex nature, severity and intensity of the health needs continue to impact on the child, the young person and/or the parents regarding their ability to provide ongoing safe care, a checklist should be completed. Completion of the checklist does not determine that a child or young person has eligibility for Continuing Care this stage. The health professional involved in checklist completion should forward the checklist within 24/48 hours of completion. The Continuing Care service will be responsible to manage a single point of access for the assessments and referral types outlined in this policy ([see Appendix 3](#Appendix)).
     5. A Nurse Assessor from the Continuing Care service will review the checklist to quality assure and determine if there is indication to proceed to CCA. This will be done within 5 working days of checklist receipt.
     6. The referrer will be informed of the outcome, providing rationale as needed. If the document is incorrectly completed or requires additional information, it will be returned to the referrer with details of how to complete the referral correctly. If a decision is made to progress to a CCA those professionals present during checklist completion will be invited to attend a meeting to complete a CCA. The MDT initially involved with checklist completion should remain involved, for continuity and consistency. Correspondence regarding CCA meeting will be sent accordingly via letter/email.
     7. The Nurse Assessor from the Continuing Care service will manage and lead the process to complete a CCA. Members of the MDT parents, child or young person (where possible) will need to participate. The assessment will comprise of:
        1. preferences of child or young person and their family (information will be sent prior to the meeting to capture a picture of the health needs, and impact, to the child young person and their parents);
        2. holistic assessment of need;
        3. reports from multi-disciplinary team;
        4. Decision Support Tool completion.
     8. It is recognised locally that a six-week timeframe commences upon receipt of the Checklist into Continuing Care. The DST is used as a document to assess health needs across ten care domains. The assessment will consider the needs and support from a social care and educational perspective, and how all the provision and support will blend together. Input from the child, young person and their parents is required to ensure a holistic picture of the needs are captured.
     9. The DST is not a stand-alone determinant to identify a Continuing Care needs, all four elements are considered. Analysis and discussions of reports, assessments, health care plans and risk assessments from services providing input will take place and will provide the supporting evidence of the health needs. All supporting information will need to be evident on the day of assessment, provided via email (where feasible).
     10. The following documents are examples of what should be provided to complete the assessment:
         1. Education, Health and Care Plan (EHCP);
         2. Social Care assessments;
         3. educational assessments;
         4. child and young person health care/behavioural plans with associated identified outcomes from specialists/clinicians within that field of care;
         5. risk assessments, care diaries/logs;
         6. health specialties care directives i.e. dietetic plans, respiratory prescription, Speech and Language Treatment plans.
     11. Recommendations will be formulated by the nurse assessor as a result of the information provided within the CCA, this recommendation should indicate if the child and young person has Continuing Care needs, and if these needs be met via a package of bespoke health support, or a contribution made towards their health and behavioural needs in residential placement. The recommendations may also detail if the child and young person does not require additional support via NHS Continuing Care.
     12. The completed DST and all supporting information will be checked, and quality assured by the Nurse Assessor after the meeting has taken place. The case is presented to the monthly multi-agency Continuing Care Panel.
     13. Parents and child and young person will be given an opportunity to describe what support they are requesting, based upon the health needs evident. This may be in the form of hours each week or each day.
     14. Consideration of support in residential placement will be managed in accordance with the process outlined, and utilisation of the Residential Settings Guidance. The assessment should capture all evident health needs of those children and young people placed in residential settings, and how these are being met.
     15. All four elements of the CCA should inform recommendations which are written by the Nurse Assessor. And should describe what unmet health needs are evident and what is required to support these needs (and by what means).
     16. The Nurse Assessor will write their recommendations after the meeting has concluded and will be based upon the totality of information gained before, during and after the CCA .
     17. For consistency, the guidance of 3 highs, 1 severe or 1 priority across the 10 care domains could indicate Continuing Care needs, which may require a package of care, or contribution towards residential placement. However, in some instances although a child and young person may have Continuing Care needs there may not be a requirement to provide any additional support or provide a contribution towards residential placement. In these cases, the child and young person may already be in receipt of NHS universal/core or specialist services, which are meeting their health needs. Additionally, in some instances the LA core provision within a residential setting may be substantial in meeting a child or young person’s needs without any additional contribution.

Exceptions may apply for children and young people who fall within the remit of the Derby Section 75 Agreement.

* 1. **Decision Making (including Multi-Agency Continuing Care Panel Process)**
     1. A multi-agency panel will be held monthly unless periods of high demand necessitate additional panels. This panel will be the responsibility of the Continuing Care service MLCSU to arrange and manage. It will be attended by necessary partner agencies that have responsibility to act on behalf of their organisations, and where required can commit resources in relation to care package arrangement. Senior health professionals/clinicians may also attend to provide a local view and understanding of community services. Members of the panel will be independent from the assessment, and declarations of any conflict of interest arising should be heard before panel commencement The panel will be chaired by ICB representatives or MLCSU Lead. Terms of Reference can be found within the appendices.
     2. The Continuing Care panel will refer cases onto the Commissioning for Individuals panel, each managed respectively between the ICB and Derby City Council and Derbyshire County Council. These panels will function in respect of the funding arrangements, and agreements of contribution towards a shared package of care, treatment or therapy.
     3. The Continuing Care panel will take into consideration all aspects of the CCA holistically. The panel will not pre-judge eligibility or non-eligibility and be mindful of the suggested guidance of the level of health needs: 3 high, 1 severe or 1 priority. Consideration will be given to the health needs described within each domain and how these health needs interact and impact on each. The multi-agency forum need to consider how a shared approach to meeting all needs can best be met, through collaborative arrangements. . Panel will discuss whether the child and young person has needs that can be met by universal or specialist NHS services, or whether these needs cannot be met by them and require support from a shared approach to care from multi-agencies.
     4. Children and young people either entering or already residing in residential settings will be discussed and reviewed as required by panel members if they are held within the Continuing Care caseload.
     5. The panel will understand that the Continuing Care process is about full engagement and partnership working between the agencies, the child, young person and their family to determine the best available support and provision via a package of care in their home, preferred setting or residential setting. It is agreed that the Continuing Care panel will hold discussions about what is required on an individual case by case basis fairly and equitably, through a robust transparent process.
     6. The panel will either ratify the recommendation made by the Nurse Assessor or make additional and/or alternate decisions, based on the information and evidence presented. The panel will provide rationale for all decisions made. Rationale for alternate decisions will be recorded within minutes.
     7. The child, young person, their parents and MDT will be informed of the decision within 5 working days of the panel convening. Outcome of the panel can show:
        1. **Continuing Care need determined (eligible)** which requires a package of care/support;
        2. **Continuing Care not determined (not eligible)**, and no additional package of care/support is required from NHS Continuing Care (exceptionality may apply for cases under the ICB and County Council Section 75 Agreement). Cases not meeting eligibility using the CCA process but meet the criterion for Section 75 will be referred to the ICB for management;
        3. **Continuing Care needs determined – but do not meet eligibility criterion guidance. The CCA identifies that the health needs described cannot be met through locally commissioned NHS universal and targeted/specialist services, and require some form of alternate or additional healthcare provision –** Nurse Assessor recommendations recognise health needs that cannot be met by locally commissioned NHS services, which fall outside the remit of social care and education. Consideration can be given by panel to support towards the health needs. The panel will formally advise ICB of the need for a type of support outside of Continuing Care/ eligibility process. The panel will determine the provision of support by considering the recommendations, views and requests from child/young person and parents, and evidence presented;
        4. **Continuing Care need not determined – well managed need (in relation to behaviours that challenge and mental health needs within residential and home setting)** – panel agree that the evidence (specialist assessment/review, behavioural plans, and planned outcomes) demonstrate a well-managed need. Joint arrangements to continue, until further CCA shows the provision and support required has reduced enough to consider transfer to a setting ‘less intensive/complex’ or health and behavioural support has reduced to a level to warrant less support within placement ([see Appendix 17](#Appendix));
        5. children, young people and their parents will receive correspondence to show whether eligibility has been met, and whether a package of care is required. The panel will provide a rationale for decisions made within panel. In some instances, the panel outcome may be delivered verbally to the parents by the nurse assessor when requested;
        6. panel members should understand the premise of the Continuing Care Framework and its underlying principles. Members will ensure the National Framework guidance is adhered to and apply the joint localised working arrangements to each case; unless there is good reason not to do so. All decisions made in panel, and the processes followed will be subject to scrutiny in accordance with appeal, dispute, Parliamentary Health Service Ombudsman review;
        7. quality assurance of CCA’s and evidence used to capture levels of health need will be clinically scrutinised by clinical leads within the panel arrangement or be peer reviewed on a bi-annual basis through random sampling. Random sampling will be carried out by ICB Quality Team. Peer review and sampling will be used to understand efficiencies and gaps of CCA completion;
        8. the child/young person and or parents will be informed of their rights to appeal the panel decision through the appeal’s procedure, within panel outcome letter. The local appeals process is described within the local public information Continuing Care leaflets and Local Offer Information, held on the ICB and Local Authority websites ([see Appendices 8, 9 and 10](#Appendix));
        9. any existing cases where a care package arrangement is to be amended, and subsequent appeal is received, the care package and funding arrangement will remain in place whilst any appeal is ongoing, until an agreed outcome is reached; and
        10. independent quality assurance of CCA’s can be undertaken if the need arises and will be discussed in the panel setting.
  2. **Arrangement of Provision (Package of Care)**
     1. The Children’s Continuing Care Service will arrange provision of the package of care as soon as possible, with a suitable health care provider. This arrangement will be discussed with families and will be done via a commissioning process in order to procure a health care service. Personal Health Budgets will be discussed with the parents, child, and young person, giving them choice, control and flexibility on how the care is delivered. More information on PHB’s can be found at Personal Health Budgets.
     2. In some cases, the panel will have agreed specific targeted therapy or treatment for a child or young person and where needed will be arranged alongside the package of care.
     3. Commissioners will consider what additional care is required in order to fulfil their statutory duties to meet the reasonable needs of an individual and ensure that Continuing Care arrangement is part of a wider package of care, delivered in collaboration across Health, Education and Children’s Social Care, unless there is a good reason for this not to happen. Where the child/ young person has existing and other provision in place, these will be dovetailed with the Continuing Care package to ensure that all care provision is seamless i.e. social care direct payments, hospice support.
     4. Planning of the health care package should begin early and consider:
        1. the local multi-agency joint working arrangements and local offers of provision (these will need to be considered at the point of care package recommendation made by the Nurse Assessor);
        2. that offers of support are based upon a need’s assessment, and must be recent assessments depicting a child or young person’s current needs;
        3. the skill mixes of parents and staff required to deliver the package i.e. parents will need to be made aware that the arrangements for any care package enabling and supporting the parents, in caring for their child. Fundamentally, the intent of a care package is not to replace the parenting role, and must not impact in such a way that facilitates removal of this role from them;
        4. shared or corporate parenting (children’s social care involvement);
        5. how Continuing Care support integrates with SEND provision, universal, targeted and specialist health provision. The relevant SEND Casework officer will need to be advised of the outcomes and panel decision, depicting what health needs are being met by the provision of an integrated package of care, through use of information sharing/advisory documentation completed;
        6. sustainability of the care package (contingency planning);
        7. short and long-term outcomes;
        8. care provision not being driven by services, they should be led by the needs of the child and young person through a planned care approach;
        9. the child/young person’s home or other suitable safe environment, as the place for care provision.
     5. The commissioned package of care will need assurances of high quality, safe and appropriate care delivery by the Children’s Continuing Care service. These assurances should meet clinical governance requirements and will consist of:
        1. relevant and appropriate training and competency sign off for those undertaking healthcare interventions. This includes parents, residential staff, foster carers, family members, and Personal Assistants;
        2. plans of healthcare delivery, risk assessment and contingency provided by commissioned healthcare provider, written in conjunction with the local community/acute NHS service professionals.
     6. It is not the responsibility of the Nurse Assessor to perform the training/competency or develop care plans etc., these will be provided and performed by the commissioned services, or where feasible the community/acute NHS services. Care packages will not commence until assurance of the relevant clinical governance is in place.
     7. The Continuing Care service has a duty to ensure that clinical governance is maintained in all bespoke care package arrangements, with assurances gained from various sources to safeguard child and young person receiving health and behavioural support from NHS and independent agencies, third sector and where required from health and social care providers.
     8. The aim is to complete the process within a six-week timeframe, beginning when a child or young person is recognised to have complex health needs (checklist completion), up to the panel outcome and arrangement of the care provision t. However, it is recognised that this may not always be possible in some circumstances. In these instances, a risk assessment will be required if there is a delay in arranging care provision for the child or young person, and where necessary risks concerning wellbeing mitigated or escalated accordingly.
     9. The Continuing Care process should not be delayed and can be progressed alongside other assessments i.e. EHCP and Single Assessments, Family and Child Assessment. The decision regarding Continuing Care needs can be made outside of the EHCP process, but the EHCP must be utilised as part of the assessment. Decisions made within panel will be shared with the EHCP plan writers, in readiness for the EHCP review. Continuing Care provision should become part of the child and young person’s EHCP.

1. Care package procurement and funding agreements
   1. Individual health care packages will be procured by the Children’s Continuing Care service on behalf of the ICB. The associated due diligence and clinical governance assurances will be applied and additionally managed by the service; they will be directly invoiced by the provider for their commissioned activity.
   2. Contributions made towards LAC in residential settings will be provided via re-charge from the relevant Local Authority holding the contract. In any instance funding and financial matters will be discussed latterly after the child and young person’s eligibility status has been determined within the Continuing Care panel. The cost of a package of care is not a determinant for eligibility.
   3. Funding principles and local arrangements for Continuing Care to be managed in accordance with local agreements ([see Appendices for Section 75 Agreement Policy](#Appendix)).
   4. **Reviews**
      1. Reviews are an ongoing aspect in the Continuing Care process, providing the opportunity for the recurrent (or as required) assessment of a child or young person’s needs, and how these needs are being addressed and managed by the care package. It is understood that children and young people are in various stages of development, physical, cognitive, emotional etc and is important to understand physical health, behavioural and mental health needs alongside their development and how each impact on one another to warrant changes in health care provision.
      2. The Nurse Assessor will complete the reviews starting from three months after commencement of the care package, annually and as required (determined by changes in a child or young person’s health needs, this will include DST completion). The three-month review will not require a CCA completion, this review provides a brief overview of how the provision is working. A CCA is required at the point of the annual review or when a change of needs is indicated and will include DST completion. The CCA review enables a holistic approach performed by those involved with the child and young person.
      3. The Nurse Assessor will ensure that the child/young person and their parents understand that reviews are designed to ensure that Continuing Care being met on an ongoing basis, and that changes in health, behavioural or mental health needs may require a change in care package provision. In the case of a child or young person having SEND, the reviews will be synchronised where possible with the regular annual review of the EHCP, Child in Need Meeting, Looked After Child review etc. and information utilised across all assessments ([see Appendices 15 and 18](#Appendix)).
      4. A child or young person or their parents can request a review of health needs at any time. This request should be made to the Nurse Assessor with rationale as to why this is required. It is understood that a child’s health needs can alter in complexity, requiring amendment to denote an increase or decrease, and potentially require a different type of health support.
      5. Parents will have been advised that the care package is based upon their child’s health needs at both the checklist and DST stages of the process, and additionally as part of the review process. This information should enable parents to understand that care package provision may alter in accordance with their child’s health needs. Where shared care arrangements are in place with the Local Authority the parents will be integral to assessment and review whilst in a residential placement. Assurances of safe and appropriate healthcare support will be sought from the setting, and parents advised of this within the review process, and as required.
2. Changes to care package provision
   1. If a Continuing Care review has highlighted that the current care package is no longer required and the child’s health needs can be managed within the remit of the universal or specialist NHS services, , this will be discussed within the MDT with regards to next steps. The MDT will agree how the Continuing Care package is to be stepped down to universal/specialist NHS services, to minimise the impact on the parents child and young person. There may be a requirement for phased withdrawal of care package, which will be planned and agreed in conjunction with all those involved.
   2. Where step down is indicated the existing care team (NHS universal, targeted and specialist services) will support the transition of a child or young person into the sole management of their services, along with other multi-agencies involved at that time; early engagement with the child/young person, their parents and relevant services is key. This planned care approach must consider this transition and where necessary the continued support from social care and education. Children’s social care will review the assessed needs of the child and family via their assessment process, in a timely manner to inform and advise parents of the support they may be offered if required, from the LA following a change in need or situation.
   3. Cessation of a Continuing Care package of care does not indicate that other agencies will stop their support, agencies should continue to provide towards a child and young person’s needs as per their statutory functions, and assessment criteria.
   4. It is recognised that some children and young people experience improved physical and mental health and periods of calm and will need to be considered prior to withdrawal or reduction of care. Risk assessment should be utilised where appropriate in these circumstances. In those cases where the physical and mental health or behavioural needs increase after withdrawal of Continuing Care has taken place, a referral back into the service would be required using a checklist, following the usual process. However, where feasible and relevant the most recent DST could be utilised and amended to reflect the changes, reducing the time taken to complete the CCA.
   5. A planned withdrawal of the continuing care package will be individually agreed between the child/young person, their parents and the MDT and thereafter ratified by panel. The relevant community or acute health professional/s will be responsible for monitoring and evaluating the care plan once after Continuing Care package withdrawal, in accordance with the plans of support at that time and having knowledge and understanding of the case. Any concerns around a lack of specific health support from the locally commissioned NHS services, will be escalated to the ICB for their consideration and potential management.
   6. Consideration is given to well-managed needs within residential settings and should be captured within the assessment. Reviews which highlight the potential contribution withdrawal from health because of a well-managed need, will require discussion at panel to determine how the support continues to safely manage a child or young person in the setting. Parents will be included in the reviews of children in residential setting, where co-parenting is in place, and where it is.
   7. A care package will not be reduced or stopped on the grounds of cost, and if in unprecedented circumstances this occurs a full equality analysis of impact will be required prior to and additionally escalated to senior leadership teams in respected agencies ([see Appendix 18](#Appendix)).
   8. The child and young person’s EHCP will be amended to reflect any changes in care provision, in subsequent issue of the reviewed plan.
3. Looked After Children in Residential Settings
   1. Children and young people within residential and/or educational settings should have access to local core and specialist NHS services, and referrals made to the same as required. The MDT should refer the child and young person to specialist NHS services where required to assess, and manage health needs, or provide strategies of care/behavioural plans etc. Where this is not available, practical, or appropriate the ICB should be informed to identify how local NHS services can be accessed, prior to any referral into Continuing Care.
   2. Any funding and contribution towards the child and young person’s needs in placement would be agreed in accordance with local funding agreements/arrangements. This would include those LAC placed within local area placements, as well as those out of area.
   3. For purposes of the assessment an MDT should convene and where relevant include placement staff, social care, education representatives, NHS professionals and other registered health professionals, who are all known to the child, or represent their service, providing an account of the child or young person’s needs. The professionals will form part of the MDT and as a group will review the support being provided in placement. The MDT will gain an understanding of the child and young person’s health needs and how these are being provided for within the placement core offer. If found that the child and young person’s health needs are in excess of that placement core offer and the local NHS services cannot meet the identified needs, a checklist for Continuing Care should be considered by the MDT. This should be completed between MDT and where feasible child, young person, and their parents. The assessment should outline what cannot be met by NHS services or by the placement, or what is in excess of ‘usual’ or core placement provision ([see Appendix 15](#Appendix)).
4. Individual treatment and therapy requests
   1. Requests for treatments and therapies, (exclusive of Individual Funding Requests), will require a proforma to be completed by an NHS professional. The proforma will describe what treatment or therapy is being requested and why, showing rationale . The Nurse Assessor will follow a separate process to request funding from ICB following quality assurance of the completed proforma, where necessary the request will be discussed with the ICB and agreement to fund will be made.
   2. The Children’s Service will request ongoing information from the referrer to provide assurances of quality provision and effective outcomes, or if further treatment/therapy is required.
   3. A checklist or CCA is not required for this type of request.
5. Crisis management for a child young person requiring urgent change of residential placement, or new to placement (behavioural/mental health needs)
   1. In all circumstances there is an expectation that the appropriate services will be working in partnership with a child or young person and their parents (where relevant) to safely manage the identified needs, and where necessary follow the relevant care crisis pathways to prevent or manage crisis situations. This may necessitate the involvement of safeguarding teams and associated process.
   2. Where urgent placement is required following placement breakdown, or where there is requirement for a newly identified and urgent placement, the Local Authority involved should obtain support from specialist NHS professionals i.e. Child and Adolescent Mental Health Service/Learning Disability (CAMHS/LD) service, to ascertain what health and behavioural needs the child or young person has. This will also aid identification of the type of placement required. Advice of this nature may not always be available and is dependent upon the case being open to that specialist service, and their ability to signpost and provide support with placement. The Nurse Assessors within the Continuing Care service may be able to offer support of this nature, within the remit of their knowledge base.
   3. Ideally an assessment should be completed when the child or young person is understood to have settled in the placement, providing a clearer understanding of their ongoing needs.
   4. The Continuing Care service (where necessary) will need to have access to all relevant clinical governance from the placement i.e. assessment/reviews, plans for behavioural, emotional, and physical care, strategies, escalation plans, outcomes of care. The Continuing Service will need to be made aware if the child or young person is placed onto their caseload.
   5. MLCSU (acting on behalf of the ICB will need to have assurances that the child and young person’s needs are being met safely, competently, and appropriately, and in cases where this is not found the Continuing Care service will escalate their concerns to the LA and ICB, and where necessary liaise with the safeguarding team. Management of concerns and issues are a priority. The ICB will determine any cessation of contribution where risk and concerns are identified and should be discussed between agencies prior to cessation.
   6. If the child or young person is known to the Continuing Care service (held on the caseload) the service where feasible, will need to be informed in advance or within 48 hours of any new placement, and in addition any significant issues occurring as a result of placement. The Nurse Assessor from the service will require new or revised plans of health/behavioural management and short/long term outcomes, to ensure safe and appropriate support is being provided. Residential placement staff, and relevant members of the MDT should liaise with the local health/behavioural specialists regarding a referral into their care, or any changes to existing planned care and support.
   7. If an alternative placement is being sought the Continuing Care service should be informed within five working days of moving. The service will liaise with placement to identify what clinical governance assurances are needed, and to arrange a review of needs in relation to placement change. This is normally carried out at 6 weeks following placement move.
   8. The child and young person’s case will be discussed within multi-agency panel for update and information purposes. Any potential revised contribution towards placement will be discussed latterly within panel and provided in accordance with local funding agreements ([see Appendix 2](#Appendix)).
   9. The Continuing Care Fast Track documentation is not intended for use in emergency or crisis placement and should not be used to facilitate and speed up the process of assessment. Fast Track process is intended for end-of-life care ([see Appendix 6](#Appendix)).
6. Crisis management and contingency planning in relation to home care package breakdown
   1. All home care packages must have contingency plans in place, in the event of:
      1. provider failure;
      2. sickness or incapacity that effects the person to exercise the parental responsibility.
   2. In both cases contingency plans need to be established within plans of care and risk assessment (detailed within CCA), and agreed between child/young person, their parents and multi-agencies.
   3. It is important that parents maintain their own competencies in relation to carrying out health care interventions to care for their child, in any eventuality and for day to care provision. There is an expectation that parents will assume responsibility to ensure the needs of their child are met, within reason of their child’s complex health needs.
   4. Options will be explored to provide contingent care for the child or young person, this may include wider family members and friends/informal family support network and commissioned providers. The hospital setting is not seen as a contingency, unless the child or young person’s health needs warrant hospital review/admission.
   5. The Continuing Care service will review and discuss episodes of missed or cancelled shifts with the provider, seeking outcomes of assurances of compliance with the arrangements of care package delivery. The Nurse Assessor should discuss alternate provision or other options of provision with the family in the event of continued provider failure to provide shift coverage.
7. Safeguarding
   1. The emphasis of joint policy arrangement is about ‘working together to support the child or young person’. All agencies are responsible to raise any safeguarding concerns and must be communicated between all relevant agencies involved with that child or young person. Local and national safeguarding policies, and escalation process will be referred to as required.
   2. The Nurse Assessor leading the CCA/reviews must be observant and understanding of the vulnerability of the child and young person across a variety of settings who has a disability, illness or health condition/need and be aware of any concerns raised, or visible alerts to any type of safeguarding, alongside other professionals at the meetings. Any concerns must be dealt with in accordance with process/policy and discussed between multi-agencies/parents as required, and as per process.
8. Children and Young People who do not Meet Criterion for Continuing Care
   1. Circumstances may arise whereby a child or young person does not meet eligibility criterion but is identified that their complex health needs cannot be met by core/specialist NHS services, or within the remit of social care, and education provision or other available support. The Nurse Assessor may refer to this within the recommendations provided, and in these cases, the Continuing Care panel can discuss a joint arrangement of support which includes elements of additional health input. Local arrangements will determine what this support looks like. It is expected that local NHS universal and specialist services will provide support in accordance with service provision and assessed needs.
   2. The ICB will be advised of these cases, and where necessary, formal request made to ICB to consider supporting towards the unmet health needs outside of Continuing Care eligibility. These cases will follow the process outlined within the National Continuing Care Framework with regards to assessment, review and transition arrangements.
9. Special Educational Needs and Continuing Care
   1. Ordinarily local authorities and ICB must make joint commissioning arrangements for education, health and care provision for children and young people with SEN or disabilities (Section 26 of the Children and Families Act 2014).
   2. Wherever possible, the EHCP assessment for those going through the CCA process will be brought together to articulate a single set of needs and outcomes. The health needs of children and young people should be reflected in the EHCP. The same information and professionals will be involved in either or both processes.
   3. Where a child’s needs can only be met through a specially commissioned service, it is the responsibility of all key partners to review the package and where possible have any agreement for ICB funding prior to the provision/placement. This should also be ratified at the Continuing Care Panel in order to provide information relating to potential future provision requirements; and a record of decision making for future purposes.
   4. If a child does not have an EHCP an Individual Care plan (ICP) must be in place within the school setting and should be used within the Continuing care process, informing about the child’s complex health needs within the education setting ([see Appendix 20](#Appendix)).
10. Multi-Agency Disputes, Disagreements and Resolution
    1. Disagreements occurring either in or out of the Continuing Care panel arrangement between health and the LA representatives should be managed at the point of disagreement where possible, to foster a culture of problem solving and partnership approach.
    2. Disagreements occurring between MDT members at the early stages of checklist should be managed between the MDT, and not escalated to the panel arrangement. Where required the Continuing Care service should be contacted for advice, with regards to disagreement about referral into the service. Parents who disagree with the outcome of discussions at checklist stage have the right to complain and should be raised to the most appropriate health professional within the MDT. Advice can be sought from the Continuing Care service prior to escalation of complaint.
    3. The panel can singularly or collectively decide if the Disputes Resolution Process should be instigated with the aim being to resolve the dispute in a timely manner, within agreed process ([see Appendix 11](#Appendix)).
    4. The existing funding arrangement and support for the child and young person will continue until dispute is resolved between the agencies involved. If throughout process an agency become aware of a change in circumstance that may affect funding arrangement a date will be agreed between agencies from when the funding may be affected on a case-by-case basis, and any re-charge be discussed and agreed between multi-agencies. All decisions will be made irrespective of any funding issues and must not impact or affect the outcome. The ICB and LA senior leadership team will be advised of any disagreement by the chair of panel or representatives within panel, and advice sought with regards to any retrospective funding or re‑charges.
    5. At no point in this process must the parents, child or young person be made aware of inter-agency disputes. And in addition, a care package cannot be reduced or removed on the grounds of disagreement or cost issues without a full equality analysis of impact.
11. Hospital Discharge Requiring a Continuing Care Assessment (Excluding Section 117)
    1. Care package commissioning may begin when a child or young person is hospitalised and will be part of the discharge planning arrangements (with their health needs being understood and consistent to warrant safe discharge). The acute services will convene a discharge planning meeting with necessary relevant agencies. Continuing Care/ should be considered at the earliest opportunity, and checklist completed if indicated, as per process. If the checklist highlights the need for a CCA, the Nurse Assessor will carry out a CCA alongside MDT at the earliest opportunity and at least within a maximum of two weeks of the decision being made to hold a meeting. The child, young person and their parents should be integral to this meeting and should be kept informed and updated on process progress throughout.
    2. The process to arrange care package provision for children and young people with the most complex health needs, can be expected to take eight to twelve weeks at least, due to necessary recruitment and training requirements by the commissioned care agency/provider. The success of the discharge plan will be dependent on maintaining momentum with a phased discharge planned approach, stepping up time at home as more carers become trained on the package, or accessing school with trained and competent carers. It is essential that momentum to develop care package arrangement is maintained to prevent delayed discharge, and the breakdown of a commissioned care package.
    3. If momentum is not being achieved and the child or young person is not spending time at home, or school as expected within the discharge plan, an MDT meeting will be convened by the lead consultant or appropriate health professional to review the feasibility of the current plan. The MDT will decide whether there is a change in health need which is preventing a safe discharge. If so, the CCA will be updated by the Nurse Assessor and findings discussed between MDT to agree next steps. The commissioned care provider (nursing/care agency) will receive formal notification that the care package is no longer required until such time when the health needs are understood. If a change in need is not identified the discharge plan will be reviewed to ensure the family have adequate and appropriate support from the MDT, including community nurses to ensure a seamless transition into the community. It is not the responsibility of commissioned care providers to transition children or young people with complex health needs from acute care to community care; this is the role of NHS health professionals based across settings.
    4. In exceptional circumstances the ICB and Local Authority involved may need to secure support through an independent Nursing Agency, with risk assessments showing adverse impact if this does not occur. This may include. qualified/fully trained and experienced workforce of registered nurses, providing interim arrangement whilst the procurement process is progressed and care package arrangements with the successful provider are completed e.g. care staff recruitment and training. Discussions to agree to the type of support will occur either as an ‘out of panel decision’ between the commissioning agencies or placed on the next panel agenda (whichever is deemed appropriate).
    5. The safety of the child or young person is paramount, and concerns regarding the additional cost of a nursing agency should not prevent access to assessed needs of complex support. It is important however that arrangement of support specifically delivered by registered nurses does not build expectations of ongoing provision within the family, and that the inappropriateness of this as a longer-term solution is stressed with regards to the delegation of health tasks, and fair and equitable health care support. Parents will need to be advised of the importance of having long term carers who are trained and competent in meeting health provision, and who meet the child’s holistic needs, and not merely their clinical needs.
    6. The Council, Hospital, or Commissioned Provider should inform the Continuing Care service of the planned discharge date and thereafter within 24 hours of a child ‘s discharge from hospital or as soon as they have been made aware.
    7. Housing organisation and Occupational Therapy should be integral to MDT arrangement for those cases where the family require re-locating to a new property, or adaptations made to existing property. Time frames for adaptions should be articulated to aid timelines of discharge, and any contingency planning for interim discharge arrangements i.e. step-down setting.
12. Step-Down Provision from Acute Hospital (Child or Young Person with Physical Disability Needs)
    1. Early identification of a child or person’s ‘usual’ home residence is required to determine if the home environment is deemed suitable. Consideration can be given to step-down provision if there is a significant waiting time for home adaptations, or new housing needs to be sought.
    2. The ICB and Local Authority will need to consider step-down provision to an appropriate venue, as a shared care approach in these circumstances. A case-by-case approach will be used to determine the needs of the child and young person, considering parental responsibility and ability, utilising individual agencies assessment of needs and Carer Assessment (Local Authority assessment). A decision must be made between agencies with regards to funding step-down as part of the discharge process; but all funding decisions of this nature will be discussed and agreed without parental involvement. Any funding decisions should not hinder or prevent a child or young person, where risks are posed in the environment they are in, and/or it is not in the best interest for them to remain in the current setting.
13. Complaints

If the child or young person or their parents wish to complain the matter will be dealt with through the internal MLCSU complaints process, in conjunction with ICB. The child, young person and their parents will be provided with details of how to complain within correspondence sent by the Continuing Care service, and additionally provides a timeframe to appeal within ([see Appendix 8](#Appendix)).

1. Appeals

Appeals can be instigated by the child, young person, parents, carer, or advocate when a disagreement occurs, and generally can be related to the decisions made within panel, as well as disagreeing with the panel outcome itself. Information is provided to request reasoning for an appeal and will give clarity to what the disagreement is about, and whet needs to be reviewed. The child, young person and their parents will be provided with details of how to appeal within correspondence sent by the Continuing Care service. Information will be provided with regards to timeframes within appeal process resolution, as well as progress of appeal, If the appeal pertains to a change in support package, the current care package arrangements will remain in place until the disagreement resolved and outcome agreed between the child, young person, and their parents. by child and young person and parents ([see Appendices 8 and 10](#Appendix)).

1. Retrospective Review

In some circumstances a historical review of a child or young person’s complex health care needs may be required. The feasibility of such a review will be discussed with the child, young person, their parents and/or advocate, which can occur as a result of a complaint, appeal, or Parliamentary Health Service Ombudsman directive. The Continuing Care service will work jointly with all involved including multi-agencies to carry out the review as per timescales, and to gain information and evidence to carry out the review in question.

1. Qualified nursing provision for a Child or Young Person with physical, learning disability and mental health needs
   1. In exceptional circumstances the Continuing Care service will endeavour to commission nursing support to provide health care tasks that cannot be delegated to a trained and competent care worker. Qualified nurse provision will be commissioned in accordance with the tasks that the care worker cannot carry out, which can include clinical health tasks needed to care for a child or young person who has end of life needs or requires complex health interventions. The requirement and decision to commission qualified nurses will be considered internally by the Continuing Care service and ICB commissioners on a case-by-case basis. Parents will be made aware that access to qualified paediatric nurses has the potential to be restricted due to a lack of availability; however, this should not impede MLCSU commissioning process to source nurse provision where it is justified. Other measures of support will be explored if qualified nurses cannot be procured, by considering the use of trained and competent care workers to deliver specific types of support within a care planned approach.
   2. The safety of the child and young person is paramount and risk assessment will be utilised to understand and mitigate risks, where evident.
   3. The child, young person and their parents will be advised of the requirement and arrangement that the arrangement of qualified nurse input does not create any unrealistic expectations in the use of nurses on a longer-term basis. Parents will be advised of the short and long-term planning to manage the care package provision, and who this can safely be delivered by, and communicated in a sensitive manner befitting the nature of the circumstances.
2. Admission to Hospital (Child or Young Person with Physical Disabilities, Behavioural and Mental Health Needs)
   1. Admission to hospital for a child or young person with complex health needs can present an enormous challenge for the child and young person, their parents, as well as the ward environment/staff. For this reason and also to maintain the important relationship between the health care worker child/young person and their family, consideration will be given on a case-by-case basis for the care package of support to follow the child/young person into hospital and will be individually assessed to determine whether it is feasible to assist and support in the hospital setting, in relation to aiding effective communication between child and staff, provide a familiar face of support, and assist with personal cares. If agreed, the support in the hospital would be of an assistive and supportive nature, and care staff would not carry out clinical health tasks (unless specific circumstances apply ([see Appendix 16)](#Appendix)). Primary provision for health needs whilst in hospital will always be provided by the hospital staff. In those cases where the care package is delivered within the home setting by qualified nurses, the nurses will not continue the support in the acute setting ([see Appendix 16](#Appendix)).
   2. When providing care in the hospital setting, the health care workers will maintain records following individualised plans of care for their own purpose delivering what is agreed whilst in the hospital setting. However, the overall responsibility for the care of the child and young person within acute services/hospital will remain the responsibility of hospital staff, at all times.
   3. Honorary contracts or other contractual/local arrangement would be required for homecare package staff in the hospital setting for the following exceptional circumstances, if the child or young person:
      1. requires a new package of care at home, and requires care workers to be trained and deemed competent to meet their health/behavioural/mental health needs; or
      2. is admitted to hospital and requires the existing homecare package care workers to be trained for newly identified health tasks.
   4. Under all circumstances of hospital provision there will be agreement between MLCSU, the care provider and the acute/hospital services in relation to the amount of care hours, which will be transferred into the hospital setting; some families may not require the full amount of care support that they would normally receive at home. Local arrangements have been agreed for process of hospital admission, and support from the homecare package. If the child and young person is in receipt of Direct Payments from the Local Authority for Personal Assistant care it is left to the discretion of the parents as the employer if the Personal Assistant accompanies the child or young person into the hospital setting.
3. End of Life Care and Support: Fast-Track Process
   1. Children or young people who meet the criteria for children’s palliative care nursing should receive that service and do not need to go through the Continuing Care process, which is provided by the local Community Nursing and Hospice/Palliative Care services. Continuing Care provision should not replace existing NHS or hospice services that can meet a child or young person’s palliative care needs.
   2. If the child or young person has needs that cannot be met by the available services, the fast-track process should be followed, and the associated document completed.
   3. The fast-track process will ensure decisions regarding packages of support can be agreed, where appropriate and without delay. This should normally occur within 48 hours of receipt, during office working days. A checklist and CCA document will not be required for children or young people requiring end of life care, separate documentation is utilised. For those children and young people already in receipt of a Continuing Care package of care a quick and timely review of needs is required to understand the end-of-life provision required.
   4. The Nurse Assessor will gather essential assessment information and seek an out of panel agreement for an end-of-life care package, agreed between the ICB and LAs, and thereafter the case placed on the next panel agenda for update/review. Authorisation will be sought from the ICB and where necessary the Local Authority, in accordance with local funding arrangements enabling the support to commence without delay, unless there is good reason not to.
   5. Where necessary a CCA will require completion at 3 months after commencement of a fast-track package of support, to determine the ongoing health and care provision, and will be kept under constant review. This will be handled in a sensitive manner in consideration of the circumstances. Fast track cases will be standard agenda items on all panel meetings.
4. Transition (Preparing for Adulthood)
   1. A young person moving through to adulthood will need to be prepared through a multi-agency approach considering all aspects of individual support and provision in relation to the needs that the child/young person has i.e. physical disabilities, behavioural needs, learning disability, mental health needs and life limiting conditions.
   2. The Nurse Assessor will factor in transition planning within the annual CCA, which will include joint assessments with adult Continuing Health Care (CHC) at or around their 17th birthday. MLCSU will internally plan transition meetings with the adult CHC team from the age of 14 years. Closer to their 17th birthday they will jointly carry out respective Continuing Care review and adult CHC checklist/DST to determine the pathway for the young adult. It is expected that the multi-disciplinary team from the relevant NHS and children’s services will liaise accordingly with their counterparts in adult services to additionally engage in this process as early as possible, to prepare and plan the pathway alongside the young person and their parents.
   3. Provision of Continuing Care in childhood does not mean that as an adult they will be eligible for adult Continuing Health Care or local joint funding arrangements. Future entitlement to adult NHS CHC should be clarified as early as possible in the transition planning process, especially if the young person’s needs are likely to remain at a similar level into adulthood, and this should be accomplished by undertaking an initial screening for NHS continuing healthcare at a suitable point or no later than 17th birthday.
   4. In summary, for those young people held within the Continuing Care caseload:
      1. at 14 years of age, the young person should be brought to the attention of the ICB/MLCSU as likely to need an assessment for NHS Continuing Healthcare;
      2. at 16–17 years of age, screening for NHS Continuing Healthcare should be undertaken by MLCSU Continuing Healthcare Nurse Assessor using the adult screening tool, and an agreement in principle that the young person has a primary health need or not, and whether they will move forward with the transition via Continuing Healthcare;
      3. from 17 years all care plans, risk assessments, incident forms and behaviour plans to be maintained to information social care and subsequent CHC funding applications;
      4. at 18 years of age, full transition to adult NHS Continuing Healthcare/joint funding/LA funding and or to universal, targeted and specialist health services should have been made, except in instances where this is not appropriate.
   5. It is recognised that many children and young people with continuing care needs will be dependent on others for all their care throughout their lives. There are those however with the capacity to develop independence and continuing care, alongside partner agencies should support in this transition, enabling the young person to manage their condition, with a full understanding of its implications for their overall well-being. It is important to understand and capture the views and aspirations of the young person throughout the transition process, ensuring that they are integral to the transition through to their adulthood. Advocacy will be utilised where required.
   6. A key aim of the management of the transition period is to ensure that there is appropriate early planning and intervention. The young person will require a consistent package of support during the years before and after transition to adulthood is provided. The care package arrangement may change as a result of the change in circumstances for the young person however, this change should not occur purely because of a move from children to adult services. Where change is necessary, it should be carried out in a phased manner in full consultation with the child, young person, and parents.
   7. Every young person with a package of Continuing Care who is approaching adulthood should have a Transition Plan. The Transition Process will be initiated by the Nurse Assessor, when the child reaches the age of 14 years (or before if deemed necessary), with the social worker to ensure that Continuing Care needs can be considered from Year 11 onwards as part of the EHCP assessment. The Nurse Assessor will also bring the young person to the attention of NHS CHC Services using the NHS Continuing Health Care Notification of Child Aged 14 form, as being a young person who may require Adult CHC. Every effort will be made by all agencies to identify young people potentially in need of ongoing services in adulthood as early as possible. This includes Looked After Children who are in residential settings or funded through other streams e.g. NHS England specialist commissioning (including inpatient mental health).
   8. Where a young person is not in receipt of a Continuing Care package, (usually because their needs are being met by locally commissioned NHS universal, targeted and specialist services and from within the Local Authority Children’s Services), and it is believed that they may be eligible for CHC, the young person’s lead health professional or social worker will be signposted to the adult CHC Team. All new referrals will go directly to the CHC Team from 17 years and 9 months. The process of referral will not go via the Children’s Continuing Care service, but where required be jointly managed with the adult CHC team leading on the case.
   9. To ensure that the legal responsibilities for child and adult services are discharged appropriately, transition plans will set out clearly who is responsible and why. The ICB will be responsible for ensuring that any gap in service provision from 16 – 18 years, when some children’s services may cease, is addressed.
5. Young People in the Latter Stages of Transition (not known to Continuing Care Service)
   1. If a young person is not known to the local Continuing Care service and is not in receipt of a Continuing Care package it is expected that the young person’s most appropriate health professional or social worker will refer the young person into to the adult Continuing Health Care (CHC) Team, as per adult CHC process. All new referrals from an approximate age of 17 years and 9 months will be referred directly to adult CHC team, unless the young person’s health needs depict that a package of care is required at that time. Where necessary a joint approach may be required between the CHC team and Continuing Care service, to assist and support the young person through to adulthood in ensuring local services are appropriately engaged.
   2. To ensure the legal responsibilities for child and adult services are discharged appropriately, transition plans will set out clearly who is responsible and why. In some cases, a service which is provided for children and young people may not be available from their 18th birthday. If this poses a risk to the young person reaching adulthood the ICB will need to be informed and addressed accordingly by them.
6. Equipment and Consumables
   1. Medical equipment and supplies will usually be ordered and distributed by the community nursing teams supporting the child and young person. Some of these supplies and equipment can be ordered through Community Equipment Stores which hold stock items, or for some items not available and are required in a bespoke manner should be agreed for purchase directly via ICB or the local Derbyshire Children’s Team (KITE Team), in first instance.
   2. It is the responsibility of the community nurse team (or other community health professionals) to ensure the appropriate use of resources in relation to equipment and consumables. The community nurse or other responsible health professional will ensure that parents are trained and competent in the use of any equipment.
7. Personal Health Budgets
   1. The NHS Mandate, which ICBs must follow, contains a specific objective on supporting children and young people with SEN or disabilities, including the offer of personal budgets. The families of children and young people with continuing care needs have a ‘right to have’ a PHB, which may contain elements of education, social care and health funding, (NHS Commissioning Board and Integrated Care Board (Responsibilities and Standing Rules) (Amendment) Regulations 2013) and Special Educational Needs and Disability Code of Practice (2015).
   2. Where a child or young person eligible for Continuing Care, or their parents, requests a PHB the ICB will arrange for the provision of care through this means. MLCSU will provide and manage PHB’s on behalf of the ICB according to the commissioned remit ([see Appendix 12](#Appendix)).
   3. A PHB will be arranged in one of the following ways:
      1. a **direct payment** made to the young person or their family;
      2. a **notional budget** to be spent by the ICB on care following discussions with the child or young person, and their family, on how best to meet their needs through provision of care;
      3. a **third party or managed budget** entails the transfer of a real budget agreed as above, to a person or organisation which provides the money in a way agreed between the ICB/MLCSU and the child or young person and their family (or another representative).
   4. The ICB will publicise and promote the availability of PHB’s within the Local Offer and through the distribution of leaflets aimed at young people and their families, which have been developed by third sector partners in collaboration with families.
   5. PHBs will also be offered to children and young people who have not been identified as having continuing care needs on a discretionary basis and as approved by the Chief Nurse or deputy.
8. Clinical Governance (Including Training/Competency and Oversight)
   1. The Continuing Care Service has a duty to ensure that clinical governance is maintained in all bespoke care package arrangements, with assurances gained from various sources to safeguard children and young people receiving physical health, behavioural, learning disability, mental health and emotional support from NHS and independent agencies, third sector and where required from social care contracted providers.
   2. Community nursing teams/hospital-based staff should ensure that parents and carers are trained and competent to provide the care outlined. The community nursing teams will also ensure that carers and staff based in schools have the appropriate training and competency completion. Where this is not feasible the ICB will arrange and provide accordingly.
   3. It is the responsibility of commissioned providers to ensure that any delegated care tasks are safely delivered, by trained and competent care workers. Qualified nurses providing oversight/training and competency completion must adhere to relevant guidance and directives in relation to delegation of nursing tasks and accountability, within the remit of their registration and competency.
   4. The Nurse Assessor will need to understand the training and competency of health care workers, personal assistants, and foster carers to ensure clinical governance is in place, this will include documented evidence i.e. from residential educational placements and from commissioned home care providers ([see Appendices 13 and 14](#Appendix)).
   5. For practical purposes, ward-based staff should handover care of children with complex health needs to community nurses, ensuring that they understand their needs, are trained in the use of any medical equipment and competent to meet the clinical need.
   6. Where a package of support is purchased from an independent care/nursing agency, it is the responsibility of the agency to procure appropriate training and to ensure training and competency amongst its workers as well as developing individual care plans, in accordance with local contractual arrangements.
   7. Clinical governance will be factored into a PHB arrangement, in relation to the health care tasks and provision required. This will be detailed within the support planning, care plan and indicative budget to meet a child or young person’s health needs ([see Appendix 12](#Appendix)).

Appendices – Local Arrangements and Statutory Documents

| **Appendix** | **Local Arrangements** | **Link to documents** |
| --- | --- | --- |
| **1** | Equality Impact Risk Assessment |  |
| **2** | Terms of Reference Continuing Care Panel |  |
| **3** | Single Point of Access Flowchart |  |
| **4** | Decision Support Tool and 3-month review proforma |  |
| **5** | Checklist |  |
| **6** | Fast Track Document/Process |  |
| **7** | Continuing Care Leaflet |  |
| **8** | Continuing Care Appeals/Complaints |  |
| **9** | Local Offer Information |  |
| **10** | Appeals Process |  |
| **11** | Disputes Resolution |  |
| **12** | Clinical Governance Guidance for Personal Health Budget Arrangement |  |
| **13** | Clinical Governance Guidance for Complex Care, Home and Education Settings Clinical Governance for Complex Care, Home Care and Education Setting |  |
| **14** | Clinical Governance Guidance in Residential Placement |  |
| **15** | Child Looked After in Residential Placement: Guidance for Management regarding Continuing Care Input |  |
| **16** | Transference of Care Package Arrangement into Acute and Other Settings |  |
| **17** | Behaviours that Challenge: Interpretation of Domains |  |
| **18** | Change in Needs, Amendment/Alteration in Care Package Provision |  |
| **19** | Care Package Provision for a Child/Young Person on Holiday |  |
| **20** | Health Information for Statutory Education Health and Care Plan |  |

| **Statutory Documents/National Guidance/Local Documents** | | **Link to document** |
| --- | --- | --- |
| **1** | Children and Young People’s Continuing Care Framework (2016) | [**LINK**](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499611/children_s_continuing_care_Fe_16.pdf) |
| **2** | Home to School Travel and Transport: Statutory Guide for Local Authorities 2014 | [**LINK**](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575323/Home_to_school_travel_and_transport_guidance.pdf) |
| **3** | Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth edition 2019 | [**LINK**](https://www.rcn.org.uk/professional-development/publications/pub-007366) |
| **4** | Meeting Health Needs in Educational and other Community Settings: A guide for nurses caring for Children and Young People | [**LINK**](https://www.rcn.org.uk/professional-development/publications/pdf-006634) |
| **5** | Managing Bowel and Bladder Problems in School (2019) | [**LINK**](https://www.bbuk.org.uk/wp-content/uploads/2019/12/Managing-Continence-Problems-in-Schools-2019.pdf) |
| **6** | Working Together to Safeguard Children 2018 | [**LINK**](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf) |
| **7** | Who Pays? Determining Responsibility for payments to Providers 2020 | [**LINK**](https://www.england.nhs.uk/wp-content/uploads/2020/08/Who-Pays-final-24082020-v2.pdf) |
| **8** | Delegation of healthcare tasks to personal Assistants within Personal health budgets and Integrated Personal Commissioning (2017) | [**LINK**](https://www.england.nhs.uk/wp-content/uploads/2017/06/516_Delegation-of-healthcare-tasks-to-personal-assistants_S7.pdf) |
| **9** | Supporting pupils at school with medical conditions Statutory guidance for governing bodies of maintained schools and proprietors of academies in England (2015) | [**LINK**](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/803956/supporting-pupils-at-school-with-medical-conditions.pdf) |
| **10** | Guidelines for Nasopharyngeal Suction of a Child or Young Adult | [**LINK**](https://apcp.csp.org.uk/publications/guidelines-nasopharyngeal-suction-child-or-young-adult) |
| **11** | Recommendations for Paediatric Respiratory Physiotherapy Care of the Complex Child in the Community | [**LINK**](https://apcp.csp.org.uk/publications/recommendations-paediatric-respiratory-physiotherapy-care-complex-child-community) |
| **Local Documents/Processes/Guidance** | | |
| **12** | Direct Payments (Derby City Council) |  |
| **13** | Direct Payments (Derbyshire County Council) |  |
| **14** | Transition Planning, Preparing for Adulthood (Derby City Council) |  |
| **15** | Transition Planning, Preparing for Adulthood (Derbyshire County City Council) |  |
| **16** | Personal Health Budgets (Derby City Council) |  |
| **17** | Personal Health Budgets (Derbyshire County Council) |  |