NHS
Heywood, Middleton and Rochdale
Clinical Commissioning Group

ROCHDALE
METROPOLITAN BOROUGH
COUNCIL

Interagency Protocol for Children with Complex/Continuing Health Care Needs

Terminology used in the document:

- RBC – refers to Rochdale Borough Council
- HMRCCG – refers to Heywood, Middleton and Rochdale Clinical Commissioning Group
- CHC- Continuing Health Care
- Complex/continuing health care needs – refers to children and young people who may have special educational needs/disability/complex health needs
- Child and Young Person – relates to children and young people up to the age of 19 years

CONTENTS

1.0 INTRODUCTION

1.1 Aim

This protocol has been developed to formalise the partnership arrangements between Heywood, Middleton and Rochdale Clinical Commissioning Group (HMRCCG) and Children's Services Rochdale Borough Council (RBC) to support the assessment and decision making processes for children and young people up to the age of 18 years or (19 years if the young person has special educational needs) with complex, persistent and severe behavioural, medical and mental health needs.

It will:

- Set out single agency responsibilities
- Describe the mechanism by which the two organisations can jointly reach agreement as to the needs of children and young people with the most complex needs
- Set out the criteria for joint or tripartite funding arrangements required to meet those needs.

This protocol is supported by a number of assessment tools which are referred to throughout this document and by Responsible Commissioner guidance (ref: *Who pays? Establishing the Responsible Commissioner 2007 Department of Health*).

1.2 Objectives

This agreement between HMRCCG and RBC applies to:

- children and young people with complex, persistent and severe behavioural, medical and mental health needs aged 0-18/19 years (as described in 1.1), and
- who have needs at Level 3-5 on Rochdale Borough's 'Children's Needs and Response Framework' (appendix 1)

The protocol will provide a framework which both organisations can use to assess the needs of children and intervene effectively to improve their outcomes.

1.3 Principles

- Services will safeguard and promote the well being of children and young people.
- Children and Young People are usually best cared for by their family, in familiar surroundings and in a way that is most appropriate to their circumstances and with the support of a wide range of practitioners and agencies.
- Children and Young People should have equal access to a range of high quality services.
- Children and Young People should have their wishes and feelings taken into consideration.
- The needs of children, young people and their families should be assessed holistically within an agreed multi-agency framework.
- Children, Young People and their families should be active partners in identifying their needs and accessing appropriate services.

- All agencies work in partnership to deliver integrated services for children, young people and their families.
- All children, young people and families have a right to receive appropriate services, irrespective of ethnicity, religion, disability, gender or socio-economic status.

2 SINGLE AGENCY RESPONSIBILITIES

2.1 Standard Services

For the purpose of this document standard services are services which are commissioned and provided through mainstream funding by health, and the local authority.

These include (but are not restricted to), for example:

- Health – primary care (e.g GP, pharmacy, dental); community (children's therapy and nursing services), secondary (hospital urgent care, in patient and out-patient care), tertiary (specialist hospital care, including in patient mental health provision);
- Local authority – social care, education services, housing, youth services, Youth Offending Team, Sure Start, drug action teams, Positive Steps, schools
- Other statutory sector services – drug action team, police, probation and the prison service;

2.2 Health

The NHS is responsible for arranging and funding a range of services to meet the assessed needs of people who require continuing physical or mental health care. The range of services the NHS is expected to arrange and fund includes:

- Health promotion and prevention
- Therapy services
- Primary health care support
- Community health services
- Acute hospital care
- Rehabilitation
- Specialist health care support
- Health care equipment
- Palliative care and end of life care.
- Mental Health Service (Child and Adolescent Mental Health Services)
- Continuing Health Care

In line with Responsible Commissioner Guidance HMRCCG is responsible for commissioning healthcare for children and young people who are registered with an HMR GP. In relation to RMBC children who are placed out of area (after 1 July 2007), HMRCCG remains the responsible commissioner for 'secondary healthcare type services' irrespective of where the child/young person is placed and if they subsequently register with a GP elsewhere for the following groups:

- Looked after children and children leaving care
- Pupils with statements of special educational needs attending residential special schools
- Children with continuing healthcare needs requiring residential care who are not looked after children
- Young adults with continuing healthcare needs.

Following the NHS reforms in 2013 commissioning responsibility for the above is split across NHS England, Clinical Commissioning Groups, Public Health and Local Authorities. This

agreement applies only to the provision that is directly the commissioning responsibility of HMRCCG. However the CCG will work jointly with other NHS commissioning bodies where needed to ensure a seamless approach around the child/young person.

It is expected that the majority of children's needs will be met through existing commissioned services. This agreement will primarily support those children and young people for home continuing healthcare applies, or where the individual circumstances of the child/young person are such that access to existing commissioned provision is insufficient or compromised.

2.3 Local Authority Social Care

RBC's Children's Social Care Service is responsible for ensuring that a range of services are available to meet the assessed social care needs of the individual children/young people and their families subject to agreed levels/priorities. The range of services Children's Social Care will include:

- Assessment of needs using various assessment frameworks e.g. Single Children's Social Care Assessment of the child's needs; within the context of their family and community, Carers Assessment.
- Case management for children who are cared for, children who are subject to a child protection plan, and children in need as defined by s17 Children Act 1989 and who tend to have higher level or complex needs (levels 4 and 5 of the Children's Needs and Response Framework
- Provision of accommodation for children who are cared for. The needs of the vast majority of looked after children will be met within mainstream provision with support from the local authority and those children will access universal health and education provision. This includes age appropriate care to promote health, safeguarding, enjoyment and achievement, making a positive contribution, achieving economic well being and promotion of family relationships.
- Provision of adoption and post adoption services- reflective of those services provided by children's social care.
- Provision of services to prevent the unnecessary escalation of children's need which if not provided my result in their for a child to be looked after (family support, short breaks, family group conferencing)
- Provision of services to prevent the need for a child protection plan (social work support, family support, co-ordination of child in need plan).
- Provision of services to promote inclusion including information and advice to families, aids and adaptations, short breaks, home care and family support.

2.4 Local Authority Education

- Education is a compulsory universal service for children between the ages of 5 and 16 and in practice many children begin to access educational provision from a much earlier age. All children including those with complex needs have the right to express a preference for placement to be made at a special school. In all cases local authorities must comply with parental preference subject to three criteria about the ability of the school to meet the child's needs, the compatibility of those needs with the needs of the other children in the school and the efficient use of resources.
- The needs of the vast majority of children can be met via placement in local maintained, either mainstream or special, school and the Local Authority provides a range of specialist services to support schools in addressing these additional needs. However, a very small group of children with the most complex needs may need placement outside the Borough in more specialist

settings as determined by their EHC Plan. The process followed in making decisions about external placements is outlined later in this document.

2.5 Interagency working

All children may have involvement from standard services from one, two or three statutory agencies. It is expected that all services will work together effectively using the interagency processes of common assessment, lead professional coordination and Family Support meetings. In cases where the needs of a child with complex needs are escalating, and standard services are struggling to meet the child and family's needs, the processes and pathway within this document will be triggered. Recognition of escalating needs is required in order to ensure early intervention with the aim of developing a package of care that averts a crisis situation for the child/young person.

3.0 PROCESS

Two mechanisms will be in place to identify the needs and agree appropriate support packages for children and young people with complex/continuing health care need:

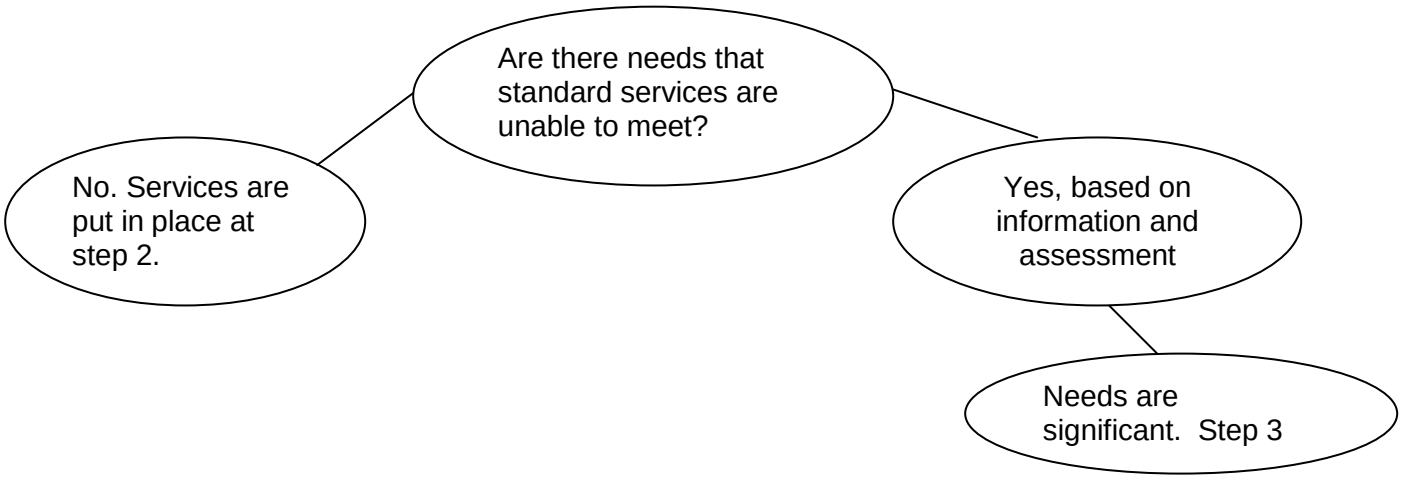
- the Children with Disabilities Resource Panel (CWDRP) (see 3.2)
- the Multi Agency Complex Needs Panel (MACNP) (see 3.3)

The CWDRP will be used to commit mainstream services and budgets(within the respective schemes of delegation); the MACNP will consider exceptional cases where additional services (often out of borough and not part of standard commissioned services) are required to meet the needs of the child/young person.

The pathway from the point of identification of need through to agreement through MACNP is described in point 3.1 below

3.1 Pathway-Identifying complex/continuing health care needs

Step	Action	Supporting tools/Arrangements
1	Unmet needs identified. Lead professional appointed. Multi- agency family support meeting/ Care Planning meeting arranged. Detailed professional assessments requested.	Common Assessment Framework Lead Professional guidance Information Sharing Protocols Agreed integrated care pathways
2	Family support/Care Planning meeting held. Multi-agency Plan developed including clear identification of all needs with plan to meet needs. Refer to Children with disabilities resource panel (CwDRP)	Family Support Meeting guidance Care Planning Guidance Outcomes Focused Planning approach used to develop plan. Continuing healthcare screening tool Education, Health & Care Plans



3	Designated professional* assesses case information and identifies need for enhanced multi-agency response (i.e. over and above what standard services can provide). NB Case can be raised at the Multi-Agency Complex Needs Panel (MACNP) at this stage for advice.	Interagency Protocol for Children with Complex/Continuing Health Care Needs

4	MACNP screening tool completed by Designated Professional	Screening tool *Appendix 2*
5	Supporting evidence collated and sent with completed Screening Tool to MACNP	Examples of supporting evidence (see Screening tool)
6	Team manager/ Designated Professional (if needed) attend MACNP and presents information on child's needs plus options for meeting these.	Criteria for identifying partners *Appendix 4* Details of the decision will be documented
7	MACNP make decisions regarding the assessment and service provision.	
8	Where funding is indicated, the MACNP will identify bi and tri-partite funding of packages and make decisions.	Interagency Funding Profile Guide *Appendix 5*
9	In the event of a serious and persistent failure to agree, the Chair will refer the matter to Executive Directors in HMRCCG and RBC.	Dispute resolution process
10	Progress in relation to agreed funding arrangements can be reviewed at the monthly MACNP meeting. In addition there is an annual review in January conducted by funding partners, of all current commitments in order to plan and agree the financial commitments for the following financial year.	• MACNP monthly meeting decisions record • MACNP Annual Review form

* The designated professional can be from any service.

3.2 Children with Disabilities Resource (CwDRP)

3.2.1. Role and Remit

- Meet twice monthly
- Receive assessments identifying a need for support services to disabled children, young people and their families.
- Determine the level of support to be provided and the funding arrangements for it.
- Aim to ensure early response to prevent escalation and subsequent costly out of area placements.
- collate data to inform service commissioning, including re-design
- monitor effectiveness of local services
- ensure greater transparency of decision making
- monitor progress towards integrated working with the aim of continuing to improve this

3.2.2 Membership

The Panel is made up of representatives who are able to commit resources:-

- CCG (Continuing Care) as required
- Head of Service SEN & CWD
- Team Manager (CWD Social Work)
- Team Manager (CWD Resources)

- Other practitioners as relevant
- Finance where necessary

Chair: Head of Service SEN & CWD
Administration Support: CWD Team Admin

3.3 Multi-Agency Complex Needs Panel (MACNP)

3.3.1 Role and Remit

The Panel will

- meet monthly
- maintain an overview of children and young people with complex needs and support an increased awareness across the agencies of the presenting needs
- aim to ensure a consistent multi-agency response both within standard services and in enhanced responses
- have arrangements in place to regularly review all multi-agency funding packages to ensure that the child/young person's outcomes are met
- collate data to inform service commissioning, including re-design
- monitor effectiveness of local services
- ensure greater transparency of decision making
- make decisions regarding levels of service provision and funding arrangements for it
- report to C&YP Partnership twice a year summarising cases referred and highlighting issues to be addressed, and to each organisation as required in line with their respective governance requirements

3.3.2 Membership

The Panel is made up of senior representatives who are able to commit resources and will include:-

- HMRCCG Commissioning Lead/budget holder for children and/or continuing care
- RBC Assistant Director, Early Help & Schools (or designated deputy) budget holder.
- RBC Assistant Director Children's Social Care (or designated deputy) budget holder.

For advice and monitoring to the MACNP:

- CAMHS Operational Manager Pennine Care NHS Foundation Trust
- Contracts/Commissioning RBC/HMRCCG
- Finance RBC/HMRCCG
- Other professional colleagues co-opted as necessary.

Chair to be one of the designated continuing care budget holders (RBC x 2, NHS CCG x1). This will be rotated on an annual basis.
Administration support to be provided by the chair.

3.3.3 Emergency Response

In the event that the circumstances of a child or young person require an immediate decision for urgent placement to ensure their safety and well-being, the case should be escalated immediately to the appropriate senior manager for a decision.

- HMRCCG Commissioning Lead/budget holder for children and/or continuing care
- RBC Assistant Director, Early Help & Schools

- RBC Assistant Director Children's Social Care

The case should then be taken through the next MACNP to reach agreement in relation to ongoing, and any retrospective, funding agreement in line with appendices 4 and 5.

4 Governance

This Protocol is agreed by both organisations through their respective organisational governance arrangements.

Monitoring of the protocol will be via HMRCCG and RBC children's joint commissioning arrangements.

An annual, year-end report will be produced by the joint commissioning team for reporting purposes both to the CCG and RBC, and to Children and Young People's Partnership

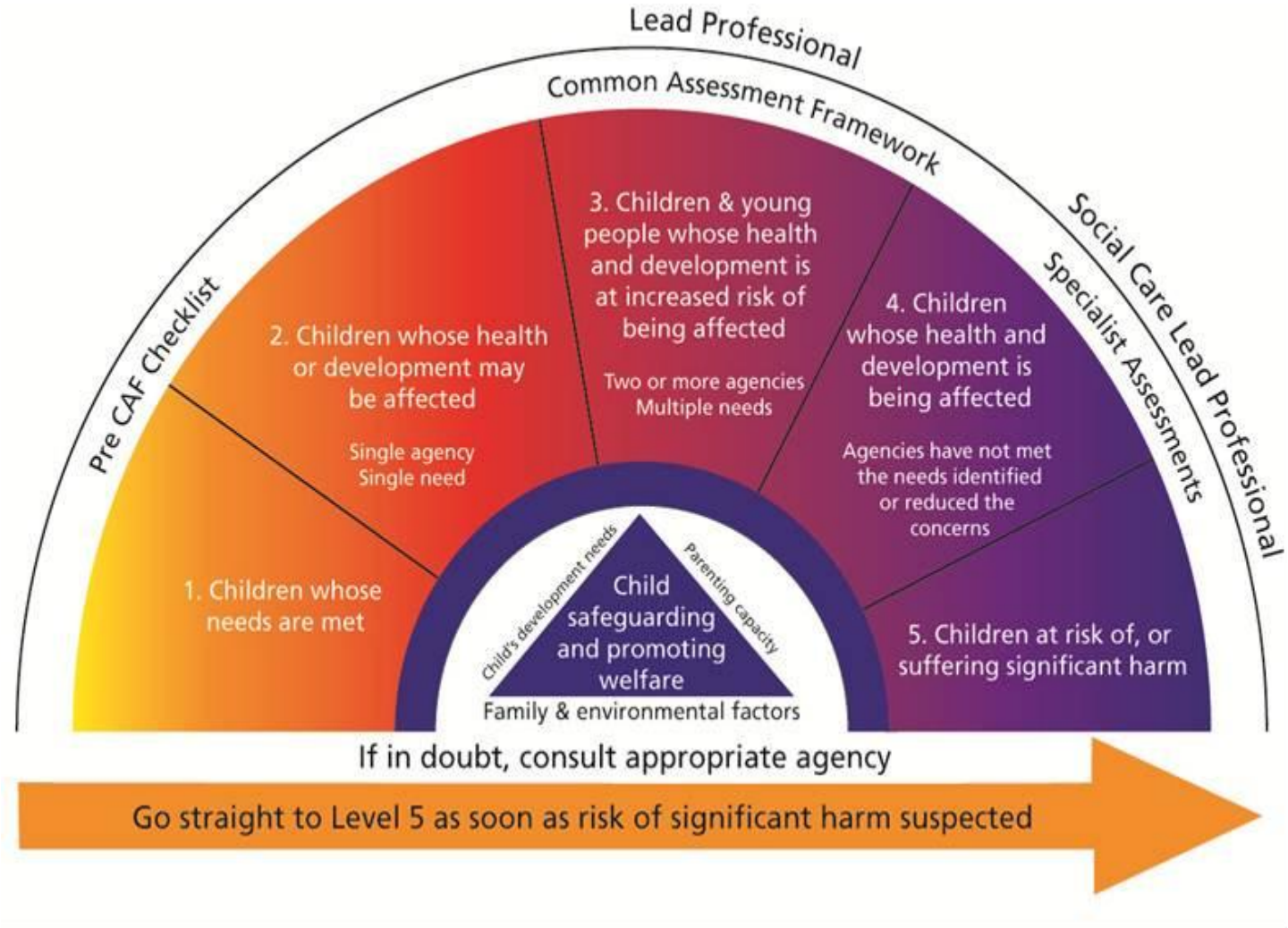
5 Dispute Resolution

In the event that agreement cannot be reached by the MACNP, either in relation to child/young persons assessed needs, the provision or funding to meet identified needs the case will be escalated to the Executive Director of Children Services (RBC) and to the Director of Commissioning and Provider Management (HMRCCG).

If resolution is not reached, final escalation will be the Chief Executive (RBC) and Chief Officer (HMRCCG).

Any dispute in funding arrangements must not delay or stop the child/young person accessing the care/provision that it has been agreed they need.

Appendix 1 Rochdale Borough Needs and Response Framework



Appendix 2 **Screening Tool**

Indicators to Consider for Referral of a Child to the Multi-agency Complex Needs Panel

Where the Multi Disciplinary Team is recommending that Continuing Health Care funding is required (as part of the multi agency support package) this information must be completed in addition to the Panel Referral Form (Appendix 2)

Please note this document is not meant to be prescriptive nor exhaustive, and is for guidance only.

Child's Name:	**Date of birth:**
Child's Address: **Postcode:**	**Ethnicity:**
Carer Name and address:	
School:	
Social Work:	
GP Name: **GP code:**	**GP Address:**

Please answer all questions by placing a tick in the appropriate box	**Yes**	**No**
Does the nature or complexity or intensity or unpredictability of the child's health care needs (and any combination of these needs) mean that regular supervision is required by a member or combination of members of a Healthcare Multi-Disciplinary Team, who will retain clinical accountability?		
Does the child has particular or intensive health needs that require trained health professional supervision to support the routine use of health care equipment, or in the event of the care being delivered in the child's own home, the family carer may be trained to provide some of the care at a level equivalent to that of a registered health professional?		
Does the child have a rapidly deteriorating or unstable medical, physical or mental health condition and requires regular intervention by a member of a Healthcare Multi-Disciplinary Team, such as the Consultant, palliative care nurse/specialist, therapist or other healthcare professional team member?		
Is the child in the terminal stage of illness with severe problems of symptom control that require intervention from a health care professional?		
Does the child have particular or intensive health needs that require nursing supervision to support the routine use of health care equipment?		
Does the child have evidence of impaired capacity (impaired cognitive functioning including orientation and memory), mental ill health, confusion, challenging behaviour and complex needs, which cannot be managed in the community by existing services and requires care in a specialised environment and requires supervision of a		

Consultant or members of the Psychiatric Multi-Disciplinary Team?		
Is the child looked after and does he/she have needs which cannot be met in in-house foster care or in-house residential care?		
Is the child looked after in in-house foster care or in-house residential care and needs substantial support to maintain the placement because of complex medical needs or severe behavioural difficulties?		
Is the child remaining within the family but needs substantial support to remain there because of complex needs or severe behavioural difficulties?		
Does the child have learning or behaviour needs or a disability of such severity or complexity that those needs create a barrier to access to the curriculum which cannot be met within the normal resources of their school?		
Does the child have a statement of special educational needs/Education, Health & Care Plan or has been permanently excluded from school?		

Current services in place for the child

Service	**Name**	**Report available Y/N and Level of Intervention**
GP/Consultant		
Social care worker		
Community nursing staff		
Education staff		
Other – please specify		
Integrated Processes - Common Assessment - Family Support Meeting - Other multi-agency meeting (please state)	Name of Lead Professional	

Form completed by: - (please keep a copy in child's records)

Name…….. **Designation. …….**

Base……. **Telephone ……**

Signature…… **Date……**

This form should be returned to ……

APPENDIX 3 Multi-Agency Complex Needs Panel referral form (MACNP)

Referral Form

1. Child or Young Person Details	
Name of Child:	DOB:
Current Address:	Current Placement Type
Legal Status of Child:	Ethnicity:
Address of Parents/Guardians (if different from above)	
Name & address of GP:	
Designation & Name of Referrer	

2. Summary of reason for referral

3. Recommendation(s) to the Panel

4. Estimated Cost and Funding Arrangements (if known)

Appendix 3 **MACNP Referral Form**
Supporting Evidence

5. Brief Referral History including alternative strategies/provision that have been tried/explored
6. Assessments/Reviews Undertaken. List with dates when completed.
7. Agency Involvement. List Agencies engaged in the referral process and details of their views, including any agreements already sought
8. Outcomes. With reference to recommendations at 3, detail the identified outcomes that are expected
9. Timescales. Please list all relevant anticipated events.
10. Review Arrangements How and when will the support package/residential placement be reviewed
Lead Agency:
Contact Tel. Number | **Date**

Appendix 4

Criteria for Partner contributions

Health (Continuing Care) Contribution

In all but the most exceptional cases children and young people who are considered for joint funding under the terms of the protocol will have continuing care needs.

The national framework for children's continuing healthcare sets out an equitable, transparent and timely process for assessing, deciding and agreeing bespoke continuing care packages for children and young people whose needs in this area cannot be met by existing universal and specialist services. It is recognised that continuing care for children and young people is organized differently to that for adults(which gives guidance on putting in place complete packages of care where and adult has been assessed as having a primary health need). Childhood and youth is a period of rapidly changing physical, intellectual and emotional maturation alongside social and educational development. This means that a wider range of services are likely to be involved in the case of a child than an adult.

The continuing care process is a three-phase activity which CCGs/ local authority and their partners undertake in order to deliver a continuing care pathway for children and young people. These three phases are assessment, decision making and arrangements for provision. The outcome of assessment will be a recommendation from the nominated children and young person's health assessor as to whether the child or young person has continuing care needs than cannot be met by existing universal or specialist services.

Every child or young person referred with possible continuing care needs will be offered a comprehensive assessment. This will be health led but will include an assessment of health, social and education needs. Decisions about a child's continuing needs will be based on an assessment of their need and not the basis of a diagnosis of a particular condition or disease.

The Children and Young People's Decision Support Tool will be used to bring assessment information together and to present it in a concise and consistent way. The support tool explores ten care domains which each have five levels of need based on a mixture of complexity, intensity, unpredictability of need and risk to the child/young person. The ten domains are:

- challenging behaviour
- communication
- mobility
- nutrition, food and drink
- continence and elimination
- skin and tissue viability
- breathing
- drug therapies and medicines
- psychological and emotional needs
- seizures

For each of these, there are five possible levels of need:

- priority
- severe
- high
- medium
- low

The assessor will decide which level of need applies to each care domain, taking into account the age of the child and the care they would be expected to need if they weren't ill or disabled.

If the child is found to have three high ratings, one severe rating, or one priority rating, it's likely that they will be eligible for NHS continuing care.

Social Care Contribution

1. The child, young person has severe learning/physical and/or emotional/behavioural difficulties (including harming and self-harming behaviours); and

2. Care for the child at home and within the extended family is seriously compromised (significant risk of harm to the child or risks presented by the child) and

3. All attempts, together with partner agencies, have been made to support and protect the child and family at home/within mainstream provision and

4. Social care needs have been identified (e.g. parental care and accommodation) and

5. Where the education and healthcare needs of the child/young person will be met by the provision of services and/or funding from the relevant agencies.

Education

1. In all but the most exceptional cases(i) children and young people who are considered for joint funding under the terms of the protocol will have a Statement of Special Educational Needs (SEN) or an Education, Health & Care Plan (EHCP). The Statement or Plan will identify clearly and in detail the child's educational needs and the provision required to meet those needs including the type of placement.

2. Wherever possible a child's / young person's educational needs will be met locally via the Local Authority's (LA) maintained provision. If appropriate an individual package of support will be considered with our partners in Health and Social Care to enable the child / young person to remain in the local area and hopefully with their home environment.

3. If it is clear that the child / young person's needs cannot be met locally other providers will be considered. Placement outside the Borough will only be made and funding agreed once the full consultation processes required by SEN legislation have been completed in order to ensure that the school / setting is able to meet the needs identified in the child's / young person's Statement/Plan.

4. All placements should be as close to Rochdale as possible to ensure that regular contact with home can be maintained. Account must also be made of the principles of Best Value both in terms of placement and travel costs.

   The partners to this agreement recognise that on occasion external regulatory or judicial bodies direct that specific placements or interventions will be made which may have implications for the partners to this agreement outside their control and outside these guidelines. We will work together to agree respective obligations, using these guidelines

(i) Children/young people who under normal circumstances would have a Statement/Plan but who for reasons of poor health / instability of home placement have not been in school for the process to be completed. NB A special school can only admit pupils with Statements of SEN/EHC Plans.

Appendix 5

Funding Profile Guide

This guide is based on the health and education needs and looked after status of the child at the time of the funding decision, and at subsequent reviews. The guide is designed to be used by the Multi-agency Panel for Children with Complex Needs.

Profile Number	Profile Description	% Funding		
		Educ-ation	Social Care	Health
1	38 week residential school placement resulting from an SEN Statement/Education Health and Care Plan	100	-	-
1a	38 week residential school placement and YP looked after/child in need. Access to mainstream health services will meet health needs.	50	50	-
1b	38 week residential school placement and YP looked after/child in need. YP meets continuing care criteria and health needs can be met.	33	33	33
2	52 week residential school placement. YP looked after. Access to mainstream health services will meet health needs. .	50	50	-
2a	52 week residential school placement. YP looked after. YP meets continuing care criteria and health needs can be met.	33	33	33
3	Residential children's home/foster care and in mainstream school. Access to mainstream health services will meet health needs. YP looked after.	-	100	-
3a	Residential children's home/foster care with special external education placement. . YP looked after. Access to mainstream health services will meet health needs. Residential component Educational Placement component	 - 100	 100 -	 - -
3b	Residential children's home that provides an integrated education package. YP looked after. Access to mainstream health services will meet health needs. . Residential component Educational Placement component	 - 100	 100 -	 - -

Profile Number	Profile Description	Educ-ation	Social Care	Health
3c	Residential children's home/foster care YP has continuing care needs and health needs can be met. YP looked after. Special/ mainstream school placement.			
	Residential Component	-	100	-
	Enhanced health component	-	-	100
	Respite component	-	50	50
	Education Placement component	100	-	-
	Enhanced support in school	50	-	50
4	Continuing Care health needs requiring high/ in-patient level care			
	Health component	-	-	100
	Education Placement component	100	-	-
	Short-break/respite component	-	50	50
4a	Continuing Care health needs and is a child in need who requires respite/short break provision.			
	Short-break/respite component	-	50	50
4b	Continuing Care health needs and has significant barriers to learning.			
	Enhanced support in school	50	-	50