NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Children and Young People's Continuing Care Policy v 1.8

Shaping better health

Please complete the table below: *To be added by corporate team once policy approved and before placing on website*	
Policy ref no:	69
Responsible Executive Director:	Rosi Shepherd
Author and Job Title:	Jane Guvenir, Head of Children's Complex Care
Date Approved:	September 2020
Approved by:	Governing body approved for publication
Date of next review:	April 2022

Policy Review Checklist

		Supporting information
Has an Equality Impact Assessment Screening been completed?	Yes	Equality Impact Assessment for CYP
Has the review taken account of latest Guidance/Legislation?	Yes	In line with the 2016 National Framework for Children and Young People's Continuing Care.
Has legal advice been sought?	Yes	Amendments included in this version of policy.
Has HR been consulted?	N/A	
Have training issues been addressed?	Yes	Multi-agency Training completed in December 2019 and January 2020.
Are there other HR related issues that need to be considered?	No	
Has the policy been reviewed by Staff Partnership Forum?	N/A	

		Supporting information
Are there financial issues and have they been addressed?	Yes	This policy governs how funds are allocated to the children and young people complex cases and governs the spend of the CCC budget
What engagement has there been with patients/members of the public in preparing this policy?	Yes	The policy was sent to 3 parent/carer groups across Bristol North Somerset South Gloucestershire (BNSSG). Comments have been considered and incorporated into document
Are there linked policies and procedures?	Yes	Personal Health Budgets Transition Both these policies are currently in development
Has the lead Executive Director approved the policy?	Yes	
Which Committees have assured the policy?	Yes	This policy has been to the Quality Committee and Policy review group and all comments are incorporated
Has an implementation plan been provided?	Yes	Included in table below on page 26.
How will the policy be shared?		Included in table below on page 26.
Will an audit trail demonstrating receipt of policy by staff be required; how will this be done?	No	The team who will be using this policy have been directly involved in developing the policy.
Has a DPIA been considered in regards to this policy?	No	
Have Data Protection	Yes	See page 23

		Supporting information
implications have been considered?		

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CYP Continuing Care Policy

1 Introduction

1.1 This policy details NHS Bristol, North Somerset, South Gloucestershire CCG (BNSSG CCG) approach to children and young people's continuing care using the principles established in the National Framework for Children and Young Person's Continuing Care, 2016 (2016 Framework). It supports partnership working between the CCG, the three Local Authorities (Bristol City Council, North Somerset Council and South Gloucestershire Council) and providers of children and young people's continuing care.

1.2 The 2016 Framework provides Clinical Commissioning Groups (CCGs) with guidance to help them in meeting the complex health needs of children and young people. It includes the framework for assessing children and young people's continuing care needs e.g. those that cannot be met by universal or specialist health services It provides advice based on existing practice across the country on undertaking a holistic assessment of the child or young person's needs. It also provides advice more generally for commissioners on meeting the needs of children with physical or learning disabilities

1.3 A continuing care package 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.

1.4 Local continuing care decisions should not be provision led and should be based on the support needs, rather than what is offered by providers. The CCG and Local Authority (LA) should agree the necessary logistical funding and, in some instances, contractual arrangements to initiate the delivery of the package of continuing care.

1.5 BNSSG CCGs application of the 2016 Framework in this policy will ensure that:

- Children, young people and their families are actively engaged in the continuing care process. The Nurse assessor/Case Manager will contact the child and family by either face to face meeting or telephone, to review eligibility.
- The process for children and young people's continuing care is co-ordinated and consistent across Bristol, North Somerset and South Gloucestershire.

- Education, health and social care practitioners and the public understand the local children's continuing care process.

1.6 BNSSG CCG acknowledges that not all children and young people will be eligible for children and young people's continuing care and that in some circumstances, it may be appropriate for BNSSG CCG to fund additional health support. Information about other types of referrals and the support available for children and young people with complex health needs is available from the CCG. This includes reference to individual funding for Looked After Children, Care, Education and Treatment Reviews and Medical Equipment requests.

1.7 The 2016 Framework is currently under revision and this policy will be updated once the new guidance has been published.

2 Purpose and scope

2.1 The purpose of this policy is to establish BNSSG CCG's responsibilities in meeting the continuing care needs of children and young people, and also to clarify the process for assessment and eligibility of children and young people who may have continuing care needs.

2.2 This policy applies to children and young people from birth up to their eighteenth birthday, who may require additional support that is not available through universal, targeted or specialist services and for whom BNSSG CCG is responsible under the NHS Act 2006. Thereafter, the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care (revised 2018) and the supporting guidance and tools should be used.

2.3 Although a child or young person may be in receipt of a package of continuing care, they may not be eligible for NHS Continuing Healthcare or NHS Funded Nursing Care once they turn 18. There is further information in section 7 on the transition process.

3 Duties – framework for this policy

3.1 The National Framework for C&YP CC places a responsibility on Clinical Commissioning Groups to secure to a reasonable extent the health care which an individual needs. The Framework sets out the process which should be followed for the equitable discharge of that responsibility for children and young people with complex needs.

The Framework was revised in 2016 to take into account the new structures of NHS commissioning created by the Health and Social Care Act 2012 and the new integrated approach to the commissioning of services for children and young people with SEND which the Children and Families Act 2014 introduced.

This policy sets out BNSSG CCG's approach to delivering CCC in accordance with the National Framework etc.

4 Responsibilities and Accountabilities

4.1 Roles and responsibilities

Children & Young People's Complex Care Team

- A team of clinicians listed below who triage, assess and deliver Children's Continuing Care packages for those CYP eligible for NHS funded packages of support.

Head of Children's Complex Care

- Provide clinical and strategic direction and lead the delivery of Children's Complex Care.
- Provide clinical and managerial support to the Children's Team
- Responsible for proposing implementation and interpretation to policies.
- Ensure quality standards of the team
- Budgetary responsibilities

Children's Complex Care Clinical Advisor & Case Manager

- Support Head of Children's Complex Care
- Responsible for co-ordination of health assessments and care plans who may be eligible for CCC or needs cannot be met by existing locally commissioned services.
- To produce evidence/analysis/proposed costed care packages for commissioners
- Triage cases / equipment requests / individual packages
- Complex case management for eligible cases
- Work in partnership with Children, families, local authorities and providers.
- Respond to patient queries
- Implementation and delivery of training program for Local Authority partners and providers.
- Attendance at multi agency funding panels, advice and support to relevant parties requesting funding from the CCG.

Children's Complex Care Nurse

- Co-ordinate health assessments and care plans for children
- To produce evidence/analysis/proposed costed care packages for commissioners
- Triage cases / equipment requests / individual packages
- Work in partnership with Children, families, local authorities and providers.
- Covering all areas, supporting the wider team.
- Respond to patient queries

Children's Clinical Reviewer & Complex Case Manager

- Work within the Children and Young People's Complex Care Team at the CCG.
- Chair of Care Education and Treatment Reviews for the 'Transforming Care' cohort. Children and young people with Autism and/or a Learning Disability who are at risk of admission to a CAMHS inpatient bed/risk of home or placement breakdown/risk of going to residential provision.
- Subsequent case management for the BNSSG 'Transforming Care' cohort. Work alongside NHSE CAMHS case managers and community CAMHS.

Children's Complex Care Team Administrator

- General Admin (set up meetings/booking rooms/travel etc.)
- Supporting the CYPCC team day to day work
- Minute taking of meetings
- Providing panel agenda and papers
- Some setting up of payments using the IT system provided

Local Safeguarding Children Partnerships

- Safeguarding children is a multi-agency concern coordinated by the local safeguarding partners within Council local authorities.

Children & Young People's Complex Care panel

This is a multi-agency panel hosted by the CCG which including LA representatives from across BNSSG and NHS provider services. Panel consider full assessments and supporting documents and determines eligibility for Continuing Care. The panel agrees funding and care package arrangements for those eligible for CCC.

4.2 BNSSG CCG is responsible for establishing and managing appropriate governance arrangements for the process.

4.3 The Director of Nursing and Quality in BNSSG CCG has executive responsibility for continuing care for children and young people and will ensure

there is effective liaison with the Local Authority and other partners. They will also ensure the effective management of the continuing care process. The Director of Nursing and Quality also has oversight of the CCGs' participation in local arrangements for Special Educational Needs and Disability (SEND).

4.4 BNSSG Quality and Governance Committee will provide the organisational governance of the children and young people's continuing care process, including receiving quarterly reports on compliance with the national framework and outcomes for children and young people.

4.5 Parents and carers with parental responsibility have the primary responsibility for the care of their child or young person with statutory agencies supporting them to meet the child or young person's identified outcomes.

4.6 The Children and Young People's Complex Care team assesses and supports the delivery of identified health outcomes for the child or young person.

4.7 There is a single point of contact for all correspondences relating to children's continuing care which is: **bnssg.cc.childrens@nhs.net**

5 Definitions/explanations of terms used

5.1 **Child or Young Person**

A child or young person aged between 0 and 18.

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

A continuing care package 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/targeted services alone. A child or young person may have very complex health needs. These needs may be so complex that they cannot be met by the health services which are routinely available from GP practices, hospitals or in the community commissioned by CCGs or NHS England. A package of additional health support may be needed. This additional package of care has come to be known as Continuing Care.

Continuing care is not needed by children or young people whose needs can be met appropriately through existing universal or specialist services through a case management approach.

The key trigger for entry to the Children's Continuing Care pathway is the recognition that the child or young person in question may have needs that require additional health services. A child or young person may be referred for assessment through a number of different routes, settings and care pathways.

Referrals are most frequently made by commissioned NHS services, Social Care and schools.

5.3 Package of Care

A package of care from one or more care providers or residential service to support the family in meeting the child or young person's health needs. This is arranged and funded by the CCG to meet needs which have arisen from disability, accident or illness.

5.4 Education, health and care (EHC) plans

EHC Plans bring together a child or young person's education, health and social care needs into a single document. A Local Authority must conduct an assessment of education, health and care needs when it considers that it may be necessary for special educational provision to be made for the child or young person in accordance with an EHC Plan. The process is conducted in line with the Special Educations Needs and Disability Code of Practice: 0 to 25 years.

EHC plans are for children and young people aged up to 25. EHC plans must specify the outcomes sought for the child or young person. The purpose of an EHC Plan is to make special educational provision to meet the special educational needs of the child or young person, to secure the best possible outcomes for them across education, health and social care, as they get holder, prepare them for adulthood.

EHC plans should be focused on education and training, health and care outcomes that will enable children and young people to progress in their learning and, as they get older, to be well prepared for adulthood. EHC plans can also include wider outcomes such as positive social relationships and emotional resilience and stability. Outcomes should always enable children and young people to move towards the long-term aspirations of employment or higher education, independent living and community participation.

The new arrangements for children and young people with SEND, in particular, provide a framework for outcomes-focused joint assessments involving different partners across Education, Health and Social Care, and many children and young people who need continuing care will have special educational needs or disability. There may be common elements to both the continuing care assessment and the EHC process assessment, and where appropriate there should be joint working to bring together a single set of outcomes.

When providing support for a child or young person with SEND who may also be eligible for continuing care, the CCG and Local Authority must endeavour to work together to assess and coordinate a jointly-agreed package of continuing

care and, in doing so, inform the health needs of the child's and young person's Education, Health and Care Plan. Where, through an assessment process for Special Educational Needs and Disability, health needs are identified which are over and above universal and targeted services, but the child does not meet the criteria for Children's Continuing Care, the CCG may consider commissioning services on an individual basis, as part of the child's EHC Plan.

All health provision detailed in an EHC Plan should be agreed with the CCG in before the EHC Plan is finalised.

5.5 **Continuing Care Process**

The continuing care assessment process typically comprises of the following phases (See Appendix A):

- The assessment, which is led by the CCG Nurse Assessor/Case Manager, will draw on the advice of other professionals.

- The outcome of the assessment is a recommendation from the Nurse Assessor/Case Manager, as to whether or not the child or young person has continuing care needs. This recommendation will be taken to a multi-agency panel who will make the decision.

- **Note.** Diagnosis of a particular disease or condition is not in itself a determinant of a need for continuing care. There should be no differentiation based on whether the health need is physical, neurological or psychological. The continuing care process should be (and be seen to be) fair, consistent, transparent, culturally sensitive, and non-discriminatory.

- The second phase, **decision-making** involves the Multi-Agency Complex Care Panel considering the evidence and the health assessor's recommendation. The Complex Care Panel will reach a decision as to whether or not the child or young person has a continuing care need.

- This is followed by the **development of a package of care** in conjunction with family and/or child or young person. The CCG will decide the level of resource which is required to deliver the care package and what elements need to be commissioned.

- When a child or young person is not eligible for continuing care, the child or young person and their family will be informed and directed to universal provision, such as GP or community paediatrician. Information on services available can be found on the "Local Offer", or the NHS website.

5.6 **End of Life**

End of life care refers to a child or young person whose condition is deteriorating rapidly characterised by an increasing level of dependency and where a lifespan is thought to be days or weeks rather than months or years. There is a fast track process and form for children and young people who are considered to be at the end of their life, see appendix E.

6 Funding

6.1 Where a child or young person is eligible for continuing care, the BNSSG CCG and the relevant Local Authority for social care and education will agree the care package taking account of the views of the family and/or the child or young person. A decision that the child or young person is eligible for continuing care does not affect the responsibility of the Local Authority and CCG.

7 Personal Health Budgets (PHB)

7.1 Under the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (as amended), the families/carers of a child or young person eligible for continuing care have a 'right to have' a PHB, covering the part of their care package which would be provided by the NHS.

7.2 When a child or young person is deemed eligible for continuing care, the Children & Young People's Complex Care Team will work with the family/carer to decide on the most appropriate way to arrange and fund the package of care.

7.3 BNSSG CCG has the following options in respect of payments for PHB's:

- A **direct payment** made to the young person (if over 16 years of age and has capacity) or their family/carer.
- The agreement of a **notional budget** to be spent by the CCG following discussions with the child or young person, and their family/carers (or other representative) as to how best to secure the provision they need.
- The transfer of a **third-party budget** agreed as above, to a person or organisation which applies the money in a way agreed between the CCG and the child or young person, and their family/carers (or other representative).

Once set up, BNSSG CCG requires a two months' notice period to cease/transfer over a personal health budget.

7.4 For more guidance on PHBs, see: "Guidance on the legal rights to have personal health budgets and personal wheelchair budgets" (December 2019) https://www.england.nhs.uk/wp-content/uploads/2014/09/guidance-on-the-legal-rights-to-personal-health-budgets.pdf

7.5 Where the family or the young person opts not to have a PHB, the CCG will make the necessary commissioning arrangements to commission packages of support.

8 Transition

8.1 Every effort should be made by all agencies to ensure that any young person (including those in out of area placements) who may require ongoing services in adulthood and who may be deemed eligible for NHS Continuing Healthcare is identified early and included in the transitions plan alongside education and social care. The key aim is to provide a consistent package of support which will ensure continuity of care, higher quality of care, better communication and ultimately better outcomes for our young people. The nature of the support package may change because the young person's needs or circumstances change and where change is necessary, it should be carried out in a planned manner in full consultation with the young person and/or parent/carer.

8.2 The CCG will work with providers during transition where the child/young person is not eligible for Children's Continuing care funding.

9 Safeguarding

9.1 BNSSG CCG has a statutory responsibility to ensure safeguarding is embedded across the work of the CCG and that safeguarding is integral to children and young people's complex care. When commissioning children and young person's continuing care, BNSSG CCG will take all possible measures to ensure that the safeguarding of children and young people is provided for within provider contracts and that care arrangements minimise the risk of harm and promote the wellbeing of individuals.

9.2 BNSSG CCG is accountable for delivering the statutory functions for safeguarding children under section 11 of the Children Act 2004, together with

its local safeguarding partners. In addition to fulfilling their responsibilities under the Children Act 2014, BNSSG CCG must comply with the statutory guidance contained within Working Together to Safeguard Children (2015) http://www.workingtogetheronline.co.uk/index.html.

The Local Safeguarding Children Partnerships provide the operational procedures that all CCG staff must follow if a situation arises during the commissioning or delivery of a children or young person's continuing care package which places a child at risk of harm.

9.3 BNSSG CCG is required to deliver the statutory functions for safeguarding adults under the Care Act 2014. Although this policy relates to children and young people, it is recognised that a situation may arise during the commissioning or delivery of a children or young person's package which places an adult at risk of harm. The Safeguarding Adults Multi-Agency Policy, agreed by the BNSSG Safeguarding Adults Partnerships must be followed if there are concerns.

10 Continuing Care Process

10.1 BNSSG CCG and the three Local Authorities (Bristol City Council, North Somerset County Council and South Gloucestershire Council) have agreed a system wide process for children and young people's continuing care (See Appendix B).

10.2 **Referral**

The continuing care process begins when there is recognition that a child or young person may have needs that require additional health services. A child or young person may be referred for assessment through a number of different routes, settings and care pathways.
Children and young people needing a continuing care assessment will, in most cases, already be known to local services. Some will be identified due to increasing needs or changes in family circumstances.

Referrals can be made by a variety of professionals, and this should include professionals working in primary, secondary and tertiary care, Child and Adolescent Mental Health Services, community nursing teams, local authority-commissioned public health, school nursing and also education and social care.

A referral using BNSSG CCGs Referral Form (Appendix C) should be made to the Complex Care Team for the assessment process to be initiated. The referral form helps practitioners identify any unmet health need in line with the framework domains. A referral should be made when a health need is identified that cannot be met through universal, targeted or specialist health services. Consent from the young person or parents/carers must be obtained to refer to the Children & Young People's Complex Care Team including consent to share information (Appendix D).

Where the views of the child or young person are different from those of their family, the possibility of advocacy should be discussed. If consent is not forthcoming, consideration needs to be given to what alternative steps i.e. the best interest of the child, should be taken.

10.3 The additional needs (documented on the Referral Form) must have been identified through a holistic assessment, this may be through early help assessment or social work and/or child in need review.

10.4 Referrals will be triaged by two Case Managers/ Nurse Assessors within 5 working days and a clinical decision will be determined. If the information suggests the child or young person may be in need of continuing care, the assessor will arrange for a full continuing care assessment to take place.

10.5 Where it is determined that a full assessment will not take place the Nurse Assessor/Case Manager will inform the referrer. The referrer will update the family. All responses will be sent on the document in Appendix F.

10.6 End of life referrals will be fast tracked without assessment and a decision about a package of support will be made within an acceptable time frame. There is a separate referral form for end of life cases (See Appendix E for the Process Chart and Referral Form).

10.7 **Assessment**

BNSSG CCG will identify a Children's Complex Care Nurse Assessor/Case Manager to lead the process. The Nurse Assessors/Case Managers are employed by BNSSG CCG and will be a Registered Nurse. All referrals will be checked against local GP services for the responsible commissioner and then logged on to the current system in order to support planning and scheduling of cases coming to the Children & Young People's Complex Care team and for monitoring timescales for completion of the process.

10.8 If a full assessment is required, the Nurse Assessor/Case Manager will liaise with the family/carer and arrange an appropriate time to undertake the assessment. Where possible, assessments will take place jointly with the referrer, and/or with keyworkers already involved with the young person, e.g. social worker, and when possible should know the child and family well. If the referrer is not available to attend the assessment, they will be asked to provide relevant and recent information.

10.9 An assessment will demonstrate evidence based professional judgement in the four areas listed in the 2016 guidance (the four areas of assessment):

- The preferences of the child or young person and their family.
- Holistic assessment of the child or young person, based on the 10 domains as set out in the decision support tool.
- Reports and risk assessments from the professionals in the child or young person's a multidisciplinary team or evidence collated during the EHC Plan assessment.
- The Decision Support Tool for children and young people.

10.10

The assessment will cover the ten domains in the 2016 Framework, which are:

- Breathing
- Eating and drinking
- Mobility
- Continence and elimination
- Skin and tissue viability
- Communication
- Drug therapies and medicines
- Psychological and emotional needs
- Seizures
- Challenging behaviour

10.11

The Nurse Assessor/Case Manager will complete the Assessment document (Appendix G) - this will be used to assess against the 10 domains alongside other assessments that have been undertaken within Health, Social Care and Education, along with the input of the family, to form a holistic picture of the child and family's needs. If the child or young person has an EHC plan, social care assessment and any other clinical information from within the last 12 months, then this must be included. The assessment must identify other

elements of support that the child or young person receives including personal budget or short breaks services arranged through social care and health funded short breaks services.

10.12

Recommendation
A child or young person is likely to have continuing care needs if assessed as having a severe or priority level of need in at least one domain of care, or a high level of need in at least three domains of care. However, the level of need in a single domain may not on its own indicate that a child or young person has a continuing care need, but will contribute to a picture of overall care needs across all domains. Levels of need are relative to each other as well as to those in other care domains. It is not possible to equate a number of incidences of one level with a number of incidences of another level- that needs associated as "moderate" in two domains are the equivalent of one "high" level need, for example. The assessment will also take into account the frequency, complexity and intensity of need, unpredictability, deteriorations and instability of medical conditions.

10.13

An assessment may identify behaviours under challenging behaviours which cannot be met by health services or which would be more appropriately met by special educational support, or social care.

10.14

The 2016 Guidance states that two or more professionals must be involved when using the DST and when making recommendations as to whether a child or young person is eligible for continuing care before presentation at the Children & Young People's Complex Care panel. BNSSG CCGs DST includes a section for the Case Manager/Nurse Assessor to complete which includes their recommendation. A copy of BNSSG CCGs DST is available in Appendix H.

10.15

Decision Making
BNSSG CCG will hold a Children & Young People's Complex Care panel on a monthly basis. Cases are presented to the panel by the Case manager/Nurse Assessor and eligibility is either agreed or declined. Decisions are based on unmet health needs. The panel will have copies of the completed DST,

together with all the reports and assessments used. The Terms of Reference for the panel are detailed in Appendix I, with the draft agenda.

10.16

The minutes of the Children & Young People's Complex Care panel will clearly record the meeting's decision in respect of continuing care eligibility.

10.17

The Children & Young People's Complex Care Panel is a multi-agency panel consisting of both health and social care.

10.18

Once a decision is made on eligibility, the Nurse Assessor/Case Manager will work closely with the family and other professionals involved to identify the most appropriate package of care. This will take into account the recommendation of the health assessor on the nature of the child or young person's needs and the views of the family.

Costed care package proposals are considered separately by the Children & Young People's Complex Care Panel. These options should always be considered after a decision has been made on whether or not there is a continuing care need. The establishment of a continuing care need should not be determined by the existing package of care a child or young person receives, or who provides or pays for it. Resources will be allocated using a graduated approach based on individual circumstances and indicated clinical needs.

10.19

Package of Care
Once continuing care funding has been agreed, a personal health budget will be arranged this will be either as a notional budget, a third party arrangement or a direct payment.

10.20

Where the family or the young person opts not to have a PHB, the CCG will make the necessary commissioning arrangements.

10.21

The Children's Complex Care Nurse/Case manager will be responsible for overseeing delivery of the community support package and will provide ongoing monitoring from a commissioning and quality assurance perspective.

10.23

Review

The child or young person's continuing care needs will be reviewed three months after the package of care has commenced. The child/young person's continuing care needs will thereafter be reviewed annually or when the needs have changed. If the child or young person has an EHC Plan, the review will be aligned where possible with the annual EHC Plan review. If there is a significant change in needs, a full reassessment may be necessary.

10.24

Ideally the review should take place with the child, young person, their family and either the referrer or another professional who knows the child well. Where a child or young person is known to the Lifetime Service caseload, the Lifetime Nurse will be involved in the review. Where the child has a social care package every effort will be made to complete the review with the social worker.

10.25

For children or young people in receipt of a PHB or a joint funded personal budget, the effectiveness of the budget will be reviewed after 3 months initially and then annually. Ideally a review of both the Children's Continuing Care assessment and the PHB can be done during one multi-agency visit and wherever possible the reviews will take place at the same time as the annual review of the EHC Plan.

11 Complaints, Appeals and Dispute Resolution

11.1 BNSSG CCG recognises that there may be times when parents/carers or a child or young person may wish to raise concerns about the care provided or the decision the multi-agency panel made around eligibility. As such the CCG has developed a clear process for parent/carer to appeal against a multi-agency panel decision. The processes can be viewed in Appendix J.

11.2 Continuing care arrangements have the potential to generate disputes regarding responsibilities for health, social care and education funding. BNSSG CCG is keen to ensure that these disputes are managed locally and resolved at the earliest opportunity. However, if this is not the case, there is an interagency disputes protocol to support any further concerns.

12 Data Protection

12.1 Data held by the CCG is governed by the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 (DPA).

12.2 We rely on the following lawful basis under GDPR for processing and sharing patient information for Continuing Care purposes.

Article 6 (1)(e) processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority;

Article 9(2)(h)processing is necessary for the purposes of preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems;

However, we do obtain consent for information sharing in line with national guidance and to meet our duties under the Common Law Duty of Confidentiality.

13 Training requirements

A training package to explain the referral and CCC processes has been developed. The training will be delivered at regular intervals throughout the year as personnel changes across provider services and LA's.

14 Equality Impact Assessment

EIA screening has been completed and can be found in the policy review checklist on page 2.

15 Implementation and Monitoring Compliance and Effectiveness

The policy will be implemented as detailed in the implementation plan on page 26 and will be reviewed 12 months from publication.

16 Countering fraud

The CCG is aware of the fraud risks involved with Continuing Health Care funding, including Personal Health Budgets and Direct Payments. These include, but are not limited to:

- Deliberately failing to meet the requirements of the support plan (for example, claiming that care has been provided when it has not);
- Misuse of a PHB (for example, using the funds for purposes not agreed in the personalised care plan for a personal benefit); and
- Misappropriating PHB funds (for example, submitting false or inflated invoices to falsely represent spending to obtain personal benefit).

In the event that fraud, abuse or misuse of a Personal Health Budget is reasonably suspected, the CCG will refer the matter to its Local Counter Fraud Specialist for investigation, and reserve the right to prosecute where fraud is suspected to have taken place.

In cases of misuse or fraud relating to a Direct Payment, the CCG will take action to recover all appropriate funds. The CCG may seek repayment from the nominated or authorised person where they have been responsible for managing the Direct Payment on an individual's behalf. "

17 References, acknowledgements and associated documents

See below in appendices.

18 Appendices

Appendix	Content	Embedded Document
A	Continuing Care Phases	 Appendix A CYP Continuing Care Phas
B	Locally Agreed Continuing Care Process. This process meets the national framework guidance.	 Appendix B CYP Continuing Care Proc
C	Continuing Care Referral Form	 Children and Young People Continuing Ca
D	Consent Forms x 2	 Appendix D CYP Continuing Care Con

		Appendix D CYP Continuing Care Con
E	**End of Life Process and Referral Form**	Appendix E CYP End of Life Referral Form Appendix E CYP EoL Referral Process Fina
F	**Not Eligible Letter for Referrer**	Appendix F Not Eligible for Assessmer
G	**Assessment Form**	Children Continuing Care Assessment v3
H	**Decision Support Tool**	Children Continuing Care DST v5 25.02.2
I	**Children & Young People's Complex Care Panel Terms of Reference**	CYP Continuing Care Panel Terms of
J	**Appeals**	CCC Appealing A Decision Leaflet 27.0
K	**Safeguarding Adults Multi-Agency Policy**	BNSSG_Safeguarding_Policy.pdf