



## Health assessments and duties

Under the Children and Families Act 2014, Clinical Commissioning Groups (“CCGs”) and other health bodies are required to co-operate with the local authority in jointly commissioning services, ensuring there is sufficient capacity contracted to deliver necessary services, drawing the attention of the local authority to groups and individual children and young people with SEN or disabilities, supporting diagnosis and assessment, and delivering interventions and review. CCGs have a specific duty to arrange the health provision specified in a child or young person’s Education, Health and Care Plan – a major change from the previous system.

Health services for children and young people with SEN or disabilities include those provided by paediatricians, psychiatrists, nurses and allied health professionals such as occupational therapists, speech and language therapists, habilitation trainers, physiotherapists and psychologists.

### The health commissioning duty

CCGs have a duty under Section 3 of the NHS Act 2006 to arrange health care provision for the people for whom they are responsible to meet their reasonable health needs.

In addition Section 42 of the Children and Families Act 2014 creates a legal duty on the CCG to ensure that health care provision specified in the EHC plan is made available to the child or young person.

The joint arrangements underpinning the plan will include agreement between the partners about their respective responsibilities for funding the arrangements, to ensure that the services specified are commissioned.

### Assessments of healthcare needs

The EHC plan must specify any health needs identified through the EHC needs assessment which relate to the child or young person’s SEN. Some health care needs, such as routine dental health needs, are unlikely to be related to SEN. The CCG may also choose to specify other health care needs which are not related to the child or young person’s SEN (for example, a long-term condition which might need management in a special educational setting).

In addition, each CCG will determine which services it will commission to meet the reasonable health needs of the children and young people with SEN or disabilities for whom it is responsible. These services should be described in the Local Offer.

Relevant local clinicians, such as community paediatricians, will participate in the development of the child’s or young person’s EHC plan, advising on the child’s needs and the provision appropriate to meet them.

The health care provision specified in section G of the EHC plan must be agreed by the CCG in time to be included in the draft EHC plan sent to the child’s parent or to the young person. As part of the joint commissioning arrangements, partners must have clear disagreement resolution procedures where there is disagreement on the services to be included in an EHC plan.

In addition, the National Framework for Children and Young People’s Continuing Care (DOH 2010) sets out the requirements for assessing children with health needs and eligibility for continuing healthcare.

The central requirements of the Framework including the following aims:

- make the child or young person and their family the focus of the continuing care process and facilitate the provision of personalised packages of care;
- cross organisational and inter-agency boundaries, thus reducing the possibility of fragmented care.

At 4.1 the framework states that:

'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.'

Where a child or young person requires services commissioned by multiple organisations, the CCG is responsible for leading the continuing care process, involving the local authority and other partners as appropriate (paragraph 12).

Nominated children and young people's health assessors are responsible for ensuring that the assessment of a child or young person with possible continuing care needs, and their families, takes place in a consistent and open manner (paragraph 18).

During the assessment phase of the continuing care process, the following should be considered:

- the preferences of the child or young person and their family;
- holistic assessment of the child or young person and their family, including carer assessment; and
- reports and risk assessments from the multidisciplinary team

The carer's assessment should consider the family capacity for resilience; this relates to a family's ability to provide care for the child or young person. The Framework recognises that parents or other primary carers need to be supported to be skilled and confident in their caring, manage the risks and ensure that quality of life is maintained for the family as a whole.

The decision-making phase usually involves a multidisciplinary, multi-agency forum in which the forum or panel will make a decision as to whether or not the child or young person has a continuing care need. The Framework provides that a decision on the package of continuing care that may be provided should not be budget or finance led: the primary consideration should be supporting the child or young person's assessed needs (paragraph 34).

## Transition to adult health services

The Code of Practice at paragraph 8.56 states that support to prepare young people for good health in adulthood should include supporting them to make the transition to adult health services. A child with significant health needs is usually under the care of a paediatrician. As an adult, they might be under the care of different consultants and teams. Health service and other professionals should work with the young person and, where appropriate, their family. They should gain a good understanding of the young person's individual needs, including their learning difficulties or disabilities, to co-ordinate health care around those needs and to ensure continuity and the best outcomes for the young person. This means working with the young person to develop a transition plan, which identifies who will take the lead in co-ordinating care and referrals to other services. The young person should know who is taking the lead and how to contact them.

For young people with EHC plans, the plan should be the basis for co-ordinating the integration of health with other services.

Where young people are moving to adult health services, the local authority and health services must co-operate, working in partnership with each other and the young person to ensure that the EHC plan and the care plan for the treatment and management of the young person's health are aligned.

The CCG must co-operate with the local authority in supporting the transition to adult services and must jointly commission services that will help meet the outcomes in the EHC plan.

## The Role of the Designated Medical / Clinical Officer

All CCGs must have a Designated Medical Officer (DMO) to support the CCG in meeting its statutory responsibilities for children and young people with SEN and disabilities.

The role of the DMO is to:

- act as a point of contact for local authorities, schools and colleges when notifying parents and local authorities about children and young people they believe have, or may have, SEN or a disability, and when seeking advice on SEN or disabilities;
- act as point of contact for local authorities, schools and colleges seeking health advice;
- supporting schools with their duties to pupils with medical conditions
- ensuring that assessments, planning and health support is carried out within CCGs. The DMO would not routinely carry out the assessments themselves but ensure they are done.

The person in this role should have appropriate expertise and links with other professionals to enable them to exercise it in relation to children and young adults with EHC plans from the age of 0 to 25 in a wide range of educational institutions.

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