



**Joint Working Protocol
Primary Care, Disability and
Child and Adolescent Mental Health Services**

September 2017

Index

Summary of Recommendations	3
1.0 Background	5
1.6 Members of the Working Group	6
1.7 Abbreviations	6
2.0 Policy Statement	7
3.0 Purpose of the Protocol	7
4.0 Scope	7
5.0 Relevant Legislation, Reports and Guidelines	7
6.0 Principles	8
7.0 Service Provision, roles and responsibilities	9
7.1 Primary Care	9
7.2 Children’s Disability Services	10
7.3 Child and Adolescent Mental Health Services (CAMHS)	11
7.4 CAMHSID Children with an Intellectual Disability	11
8.0 Referral Process	11
8.1 Pre-referral	12
Diagram 1: Pre-referral Pathway	13
8.2 Referral	14
Diagram 2: Referral Pathways for Primary Care Service, Children’s Disability Network Teams (CDNT) and CAMHS	16
9.0 Joint working and consultation	17
Diagram 3: Consultation and Joint Working	19
10.0 Communications	20
11.0 Integrated Children’s Services Forum	20
Diagram 4: Integrated Children’s Services Forum	21
11.2 Suggested terms of reference	21
11.3 Chairperson	22
11.4 Membership	22
11.5 Working Arrangements	23
11.6 Decision Making at the ICSF	23
11.7 Shared Care	24
11.8 Management of Costs	24
12.0 Resolution process	25
13.0 Implementation Plan	25
14.0 Evaluation and Audit	25

Summary of recommendations

A co-operative culture between Primary Care, Disability and Child and Adolescent Mental Health Services must be promoted, based on clarity of roles and responsibilities and a collaborative approach to service delivery.

An important aspect of cooperative and joint working is for all services to facilitate children accessing the appropriate service as early as possible to prevent multiple referrals and/or re-referrals in order to facilitate timely access to appropriate support.

The Joint Working Group recommends each area provide information leaflets/ website regarding locally available resources and activities, especially to referrers and others who are in a prime position to advise parents.

The Primary Care, Children's Disability and Child and Adolescent Mental Health Services will aim to make the referral process as seamless and timely as possible by collaborating to provide comprehensive information to families and other referrers and by communicating with all relevant parties effectively and efficiently.

Inappropriate referrals should either be redirected to the service which can meet the child's needs or the referrer and parents should be advised as to the more appropriate service to refer to.

When information indicates that there is more than one service that could best meet the child's needs, consultation should take place with the other service to determine which is the most appropriate or whether a joint approach is indicated.

Joint assessment may be indicated when presenting concerns or initial assessment indicates that there is a significant possibility of differential or co-morbid diagnosis of disability and/or mental health conditions.

Joint intervention and/or shared care may be required. Services need to agree on the roles and responsibilities of each service in supporting the child, including which service has lead responsibility for coordination of care and what are the responsibilities of other services.

An Integrated Children's Services Forum (ICSF) in each area will provide a formal, regular mechanism for services to meet and discuss individual children whose needs are not clear or who require some level of joint assessment or intervention and for whom direct consultation between the relevant services has not led to a decision on the best arrangement for the child.

In situations where differences arise in relation to the management of a case and a local joint decision cannot be agreed, the practitioners from the different services must make every effort to resolve them so that appropriate interventions can proceed. Where this cannot be agreed, the matter must be escalated by the Chair of the ICSF to the relevant CHO Heads of Service(s).

The Chief Officers of each CHO will take responsibility to implement this protocol at operational level. In order to implement this protocol into everyday practice staff must be made fully familiar with it. A roll-out implementation plan for this protocol will be developed by each CHO Management Team in consultation with both local management and staff. A joint national oversight group will be convened with an agreed work plan to oversee the implementation of the protocol.

1.0 Background

1.1 The Joint Working Group involving Primary Care, Disability and Child and Adolescent Mental Health Services was established to produce an agreed operational protocol for children whose needs may cross these services. This relates particularly to referral, assessment, intervention and discharge of children and young people under the age of 18 years.

1.2 The request for the setting up of such a group came initially from Ms Marion Meany, Assistant National Director in Social Care - Disabilities to her counterpart in the Mental Health, Mr Jim Ryan. In addition a nomination to the group was sought from and was provided by Mr John Hennessey, National Director, Primary Care. The group commenced its work in early 2016.

1.3 There are currently two national access policies for Disabilities/Primary Care and CAMHS. These are the National Policy on Access to Services for Children and Young People with Disability and Developmental Delay (February 2016) and the CAMHS Standard Operating Procedure (June 2015). It is acknowledged that services in some areas have not yet evolved to a stage where these policies can fully and effectively be implemented.

Gaps remain in how children and young people can access support across health services when required. Wide experience shows that there are children and young people with complex clinical issues who do not fit neatly into one specific diagnostic criterion. Historically services have developed in differing ways leading to inequity and inconsistency. One aspect of this inconsistency is in joint case management of complex cases between Primary Care, Disability Services and CAMHS.

1.4 This Joint Working Protocol between Primary Care, Disability Services and CAMHS has been developed to assist staff in managing the emerging interface and to develop and enhance a collaborative partnership in responding to the needs of children. The aim is to develop a consistent approach where services are delivered appropriately, to meet the holistic needs of children and their families within available resources and in accordance with Government policies and legislative requirements. The Protocol applies to HSE and HSE-funded agencies i.e. Section 38 and Section 39 agencies

1.5 In this document:

- 'Child/children' refers to babies, children and young people, from birth to 18 years of age.
- 'Parent(s)' refers to parents, legal guardians and carers, including other family members and foster parents who care for the child.

1.6 Members of the Working Group

Pat Bennett, Chief Officer, CHO 8, Chair.

Ann Bourke, National Disability Specialist, Social Care Division

Paul Braham, Senior Operations Manager, Mental Health Division

Dr Mandy Burke, Executive Clinical Director-Galway/Roscommon MH Services

Caroline Cantan, National Programme Coordinator Progressing Disability Services for Children and Young People

Dr Philip Dodd, Developmental Lead (Clinical) MHID Services

Roisin Egan, Project Manager, Progressing Disability Services for Children and Young People, CHO 5

Seamus Feehan, Acting Coordinator, Brothers of Charity, Southern Services Autism Teams

Hester O'Connor, Principal Psychologist Manager, CHO 7 (deputising for Teresa O'Mahony)

Mary O'Donnell, Disability Services Manager, CHO 2

Teresa O Mahony, Principal Psychologist Manager, CHO 6

Justin Parkes, Primary Care Manager, CHO 7

Dr Cara Prior, Consultant Child & Adolescent Psychiatrist Galway CAMHS

Dr Toby Sachsenmaier, Senior Clinical Psychologist HSE CHO 3

The Working Group wishes to thank all those who gave feedback and suggestions at the consultation phase of developing this protocol.

1.7 Abbreviations

- CAMHS Child and Adolescent Mental Health Service
- CAMHS-ID Mental Health Intellectual Disability Service for Children and Adolescents
- CDNT Children's Disability Network Team
- CHO Community Healthcare Organisation
- GP General Practitioner
- HSE Health Service Executive
- ICSF Integrated Children's Services Forum
- JWP Joint Working Protocol
- PCT Primary Care Team

2.0 Policy Statement: It is the policy of the HSE and their partners (funded agencies) to use this protocol to ensure that children access the service(s) most appropriate to their needs.

3.0 Purpose of the Protocol

The purpose of the Protocol is to specify a pathway for children and families whose needs cross between Primary Care, Disability Services and CAMHS.

4.0 Scope

This protocol applies to all staff engaged in delivering Primary Care, Disability Services and CAMHS.

5.0. Relevant Legislation, Reports and Guidelines

- A Vision for Change. Report of the Expert Group on Mental Health Policy. Department of Health and Children. 2006
- Better Outcomes Brighter Futures. The national policy framework for children 2014-2020. Department of Children and Youth Affairs
- CAMHS Standard Operating Procedures. HSE (2015)
- Child Care (Standards in Children's Residential Centres) Regulations, 1996
- Child Care Acts 1991 – 2011
- Children First – National Guidance for the Protection and Welfare of Children 2017
- Children First Act 2015
- Children First Implementation Plan for the Health Service Executive
www.hse.ie/childrensfirst
- Children's Act, 2001
- Data Protection Acts 1988 and 2003
- Disability Act, 2005
- Freedom of Information Act, 2014
- Future Health - A Strategic Framework for Reform of the Health Services 2012-2015
- Health Acts 1970, 2007
- Healthy Ireland - A Framework for Improved Health and Wellbeing 2013-2015
- HSE Child Protection and Welfare Policy 2016

- HSE National Consent Policy 2013
- Mental Health Acts, 2001, 2008
- National Children's Strategy
- National Consent Policy. HSE. 2014
- National Disability Strategy
- National Health Strategy
- National Policy on Access to Services for Children and Young People with a Disability or Developmental Delay (2016)
- National Primary Care Operations Manual (under review)
- National Review of Autism Services – Past, Present and the Way Forward. HSE.2012
- National Standards for the Protection and Welfare of Children (HIQA) July 2012
- Ombudsman for Children Act, 2002
- Our Duty to Care - The Principles of Good Practice for the Protection of Children & Young People 2002 (DOH&C)
- Primary Care Strategy – Department of Health (2001)
- Progressing Disability Services for Children and Young People Programme
- The Protection of Persons Reporting Child Abuse Act, 1998
- United Nations Convention on the Rights of the Child
- Value for Money and Policy Review - Disability Services, 2012

6.0 Principles

Overarching Principles

- The best interests of the child are paramount.
- Services exist to support children, young people and their families, including building the family's capacity to address the child's needs.
- Access to services is equitable and transparent.
- Children are seen in a timely manner by the service (s) which best address their needs.
- Services are of high quality and evidence-based with positive outcomes for children.

Core Operating Principles

1. Co-operative culture, based on clarity of roles and responsibilities and a collaborative approach to service delivery.
2. Effective inter-agency communication and information sharing within the context of relevant policy and legislation and with due regard to the views of the child and family and the need for confidentiality.
3. Promotion of and commitment to joint and multi-disciplinary working across services and organisations.
4. Commitment to appropriate consultation when one service is planning any development or action that impacts on another service in Primary Care, Disability and Child and Adolescent Mental Health Services.
5. Responsible and effective leadership in promoting the values and principles of this protocol.
6. Whilst there is recognition of the financial and other constraints faced by services there is an onus on them to manage their resources effectively and seek additional resources where necessary to meet the child's needs. This includes highlighting to management services defined in policy which do not currently exist or are poorly developed leading to gaps.
7. Flexible allocation, including joint funding, and use of resources across HSE and HSE-funded services, commensurate with assessed needs as set out in the child's care plan.
8. Identification and delivery of training on a shared basis where appropriate.
9. Clear processes for the planning, delivery, monitoring and evaluation of services.
10. Commitment to resolving any issues arising in service delivery in the best interests of the child.

7.0 Service provision, roles and responsibilities

7.1 Primary Care

7.1.1 The objective of Primary Care services is to improve the health of the population by providing local access to services and collaborating with specialised services to provide responsive and integrated care.

7.1.2 Primary Care services are usually the first point of contact for children when concerns arise and they provide a first line of response. Primary Care services include

Public Health Nursing, Psychology, Speech and Language Therapy, Occupational Therapy, Physiotherapy, Social Work and Community Health Doctors. In addition to HSE multi-disciplinary staff, General Practitioners and practice nurses are central to primary care service provision. The Primary Care services are the main providers of support for children to address physical, social, emotional, communication and behavioural needs.

7.1.3 Access to Primary Care services is determined by the range and extent of the child's functional difficulties and the level of uni-disciplinary and multidisciplinary supports required. Children who have some difficulties and (a) do not have a disability, or (b) have a mild level of developmental delay, disability or mental health problem are seen at Primary Care level. They and their parents/carers receive information, guidance, assessments and specific interventions as appropriate.

7.2 Children's Disability Services

7.2.1 Under the programme Progressing Disability Services for Children and Young People, Children's Disability Network Teams of health and social care professionals are being established within defined geographic areas, aligned with Primary Care Networks services in each of the nine CHOs. Criteria to access Children's Disability Network Team services include the age of the child, his/her home address and his/her needs. The team members work within an interdisciplinary team model, in partnership with the family, contributing to a joint integrated plan for each child, young person & family.

7.2.2 Children's Disability Network Teams (Early Intervention Teams, School Age Teams or 0-18 Teams) are the providers of services for children with complex needs. Complex needs refer to one or more impairments which contribute to a range of significant developmental functional difficulties that require the services and support of an interdisciplinary disability team.

7.2.3 Prior to full implementation of the programme and reconfiguration into Children's Disability Network Teams throughout the country, children's disability services in some areas continue to be delivered by separate disability service providers with their own access criteria for specific cohorts of children with a disability.

7.3 Child and Adolescent Mental Health Services (CAMHS)

7.3.1 CAMHS stands for 'child and adolescent mental health services'. While a broad range of services support the mental health of children and adolescents, the term 'CAMHS' is usually applied very specifically to services that provide specialist secondary and tertiary mental health services to young people up to 18 years of age through a multidisciplinary team led by a consultant psychiatrist.

7.3.2 It is the function of CAMHS teams to provide a specialist mental health service to those aged up to 18 years old who have moderate to severe mental health disorders that require the input of a specialist multi-disciplinary mental health team.

7.4 CAMHSID Children with an Intellectual Disability

Based on *A Vision for Change (2006)* provision of CAMHS to children with an intellectual disability is based on the clinically assessed level of intellectual disability. The diagnosis of autism and intellectual disability remains the remit of primary care or social care disability services. Based on the CAMHS Standard Operating Procedure (HSE, 2015), children with a mild intellectual disability are seen by CAMHS only when there is a co-morbid moderate to severe mental health disorder. Where the child/young person has a moderate or severe degree of intellectual disability and co-morbid mental health disorder, they should be referred to the relevant Children and Adolescent Mental Health Intellectual Disability (CAMHS-ID) team.

The development of CAMHS-ID teams in all CHOs is currently underway (June 2017).

8.0 Referral Process

An important aspect of cooperative and joint working is for all services to facilitate children accessing the appropriate service as early as possible to prevent multiple referrals and/or re-referrals in order to facilitate timely access to appropriate support. Accurate initial referral to the most appropriate service facilitates effective joint working by reducing the amount of inter-agency consultation necessary in relation to inappropriate referrals. Primary Care, Children's Disability and Child and Adolescent Mental Health Services will aim to make the process as seamless and timely as possible by collaborating to provide comprehensive information to families and other referrers and by communicating with all relevant parties effectively and efficiently.

8.1 Pre-referral (see Diagram 1 P. 13)

8.1.1 Urgent referrals

If there are serious concerns about immediate risk to the safety of a child or of others, an urgent referral to the relevant service should be made without delay.

8.1.2 In all other circumstances, those who have concerns about a child's development or emotional well-being, whether this is the child's parents, teacher, or others who know the child well, should in the first instance with parental consent, discuss the issues with others who are involved with the child or are in a position to advise.

8.1.3 In situations where the child's difficulties are judged to be beyond what would be expected for a child of that age and the difficulties cause significant challenges, the child should be referred to the most appropriate service, based on referral criteria and procedures (See diagram 2).

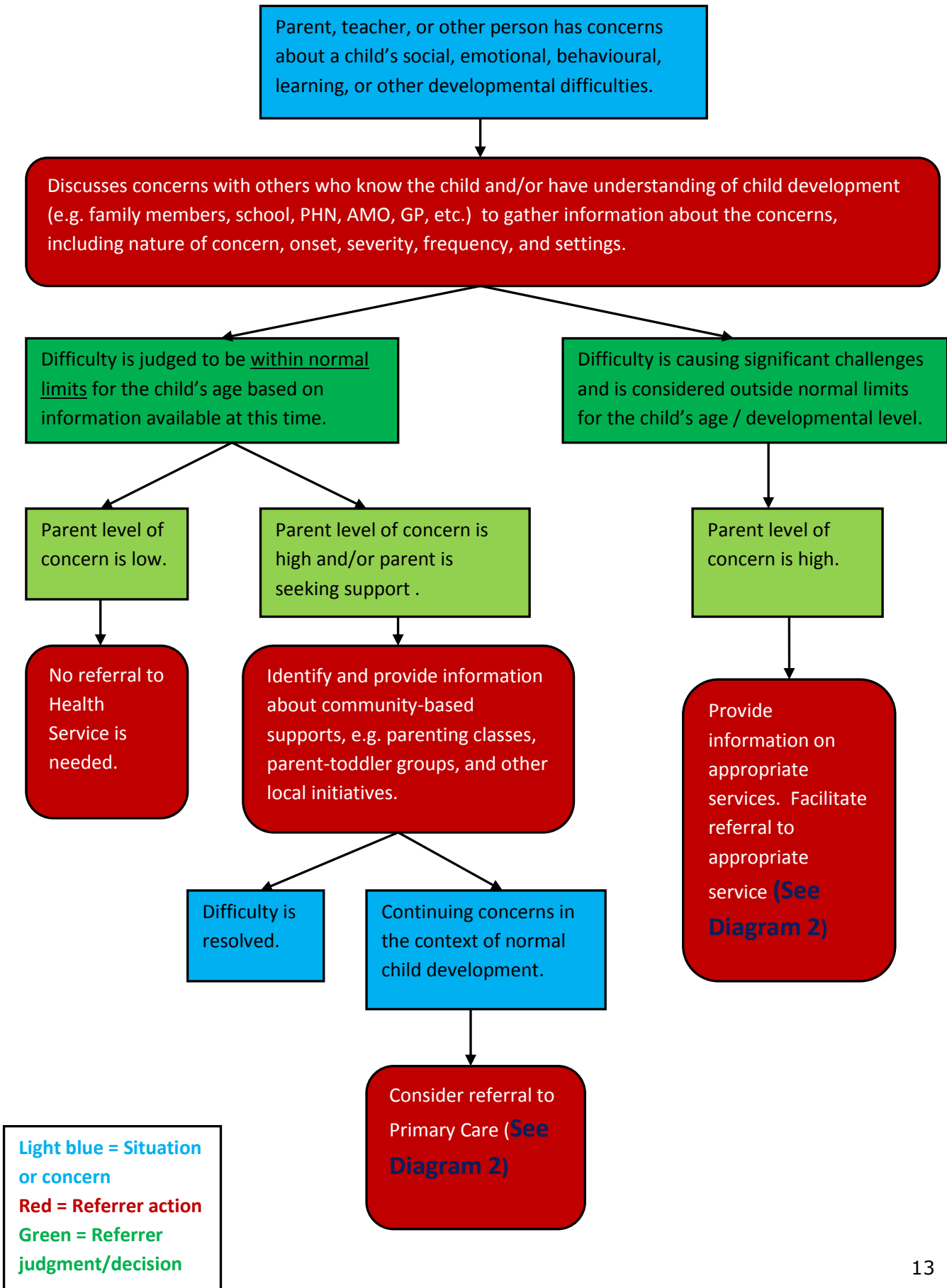
8.1.4 In situations where the child's difficulties are judged to be within the context of normal child development but the parents require support, it is preferable to recommend relevant community-based resources to provide support. This may be true if the child's difficulty is short-lived, or represents behaviour or abilities that are within normal limits for the child's age even when these are concerning to parents or difficult to manage. In these cases, children and parents may benefit from community-based supports in learning to understand and manage difficulties and concerns.

Such supports may include parenting programmes, parent and toddler groups, Community Mothers Schemes, clinician's drop-in advice clinics, and supports and activities for children and young people. The Joint Working Group recommends each area provide information leaflets/ website regarding locally available resources and activities, especially to referrers and others who are in a prime position to advise parents.

Implementation of this will be agreed locally.

8.1.5 If concerns about the child, in the context of normal child development, persist, and it is thought that referral to a health service is needed, it may be appropriate to refer the child with parental consent to the Primary Care Service for support and/or assessment.

Diagram 1: Pre-Referral Pathway



8.2 Referral (see diagram 2 P. 16)

The procedures described below should be followed by all referrers.

8.2.1 Referral forms

The relevant referral form with signed parental consent and all additional information should be sent to the most appropriate service along with any supporting information such as professional reports if available.

Primary Care Services and Children's Disability Services

On full implementation of the National Policy on Access to Services for Children and Young People with Disability or Developmental Delay 2016, Primary Care and Children's Disability Network Teams will have one national referral form for children and young people aged from birth to 18 years. Consent must be obtained in line with HSE Consent Policy.

An additional information form must also be completed, which will give the information needed to direct referral to the appropriate service. The additional information forms should be completed by parents, with the assistance of a professional if needed.

The referral form and additional information form should be sent to the service considered to be most appropriate to the child's needs based on referral criteria of Primary Care and Children's Disability Services (See Diagram 2).

Prior to full implementation of the National Policy on Access to Services for Children and Young People with Disability or Developmental Delay 2016, existing local referral forms and processes in Primary Care and Disability Services will continue to apply.

Child and Adolescent Mental Health Services

CAMHS have a national referral form which must be completed. Referrals may be made by the child's General Practitioner or by another senior health professional in consultation with the General Practitioner (see CAMHS Standard Operating Procedures).

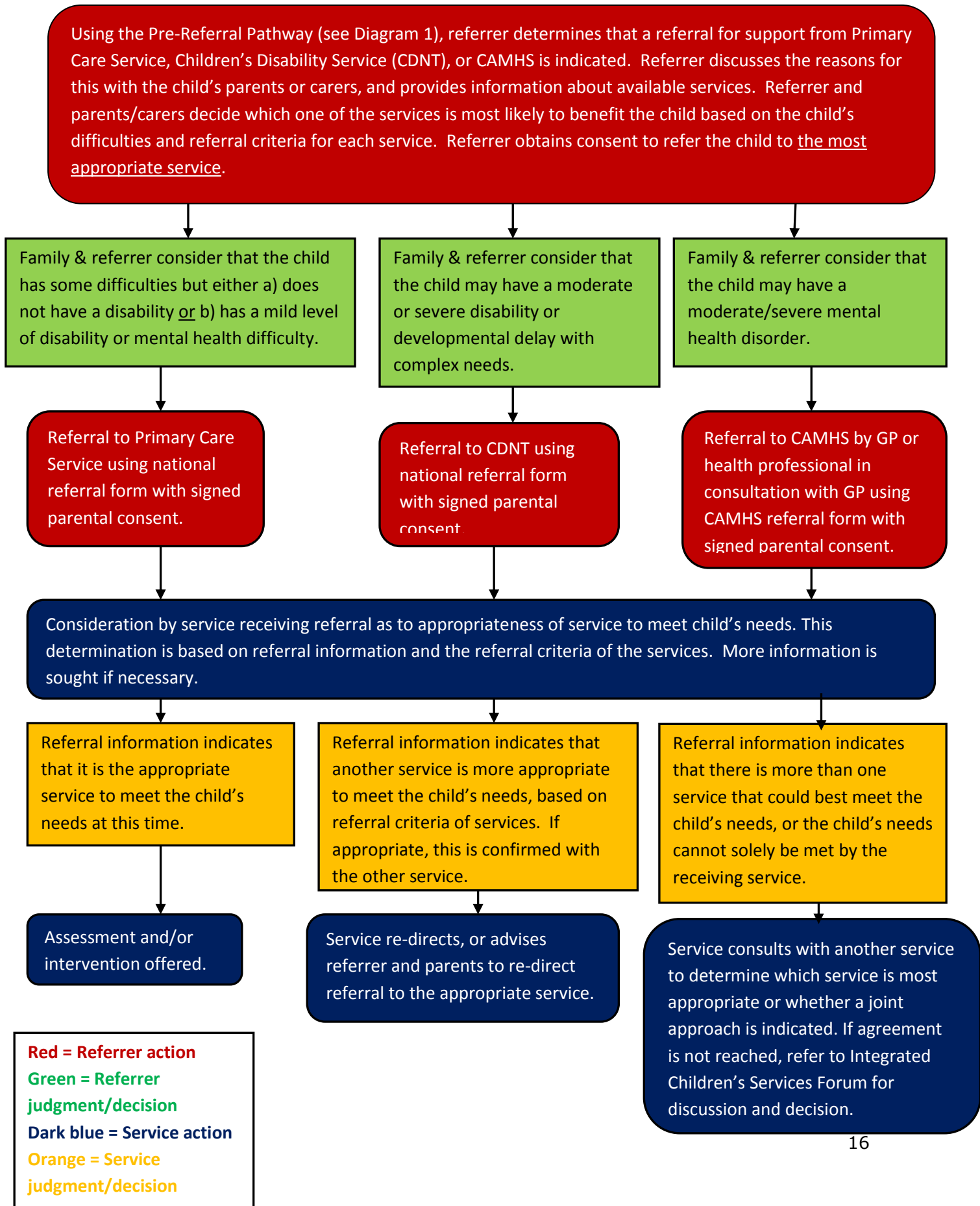
If the child has an intellectual disability, the referral will need to be accompanied by a psychological assessment confirming the level of intellectual disability. If the child has a mild level of intellectual disability with a co-morbid moderate or severe mental illness, he or she should be referred to the CAMHS team. If the child has a moderate or more severe level of intellectual disability, the child should be referred to the relevant CAMHS-ID team.

8.2.2 Procedure for managing referrals in all three services

All referrals should be acknowledged within a specified time. The service receiving the referral should consider the information and the appropriateness of their service to meet the child's needs and decide between a number of options:

- a) The service is clearly appropriate to meet the child's needs and should proceed to assess and provide intervention as required.
- b) More information is needed to make a decision on the most appropriate service and this should be sought from the parents and/or referrer.
- c) The child's needs may more appropriately fit criteria for another service. If clarification is needed the other service should be contacted directly to confirm this. Either the referral will be redirected to the other service, or the parents and referrer should be informed in writing with an explanation as to why the service referred to is not appropriate to meet the child's needs and advice as to which would be a more appropriate service for the child. If necessary either service may refer to the Integrated Children's Services Forum for discussion and decision.
- d) Referral information indicates that the child's needs cannot solely be met by the receiving service or there is more than one service that could best meet the child's needs. Consultation should take place with the other service to determine which is the most appropriate service or whether a joint approach is indicated. If following this consultation agreement cannot be reached, refer to the Integrated Children's Services Forum for discussion and decisions. If contrary to this protocol, a referral is refused by two services, the referrer or either service provider may bring this to the attention of the Chair of the Integrated Children's Services Forum for consideration.

Diagram 2: Referral Pathways for Primary Care Service, Children’s Disability Service (CDNT) and CAMHS



9.0 Joint working and consultation (see Diagram 3 P. 19)

Where a practitioner has concerns or identifies a need for advice, assessment, or intervention from another service, she/he must liaise with the relevant practitioner and agree a process for engagement. Early proactive engagement of staff in all services in the best interests of children and their families is a prerequisite for managing individual cases. Experience identifies that most inter-agency issues can be resolved by this early engagement and it can also act as an early warning system which ensures that appropriate actions are taken. If no agreement can be reached, the case should be brought to the ICSF for discussion.

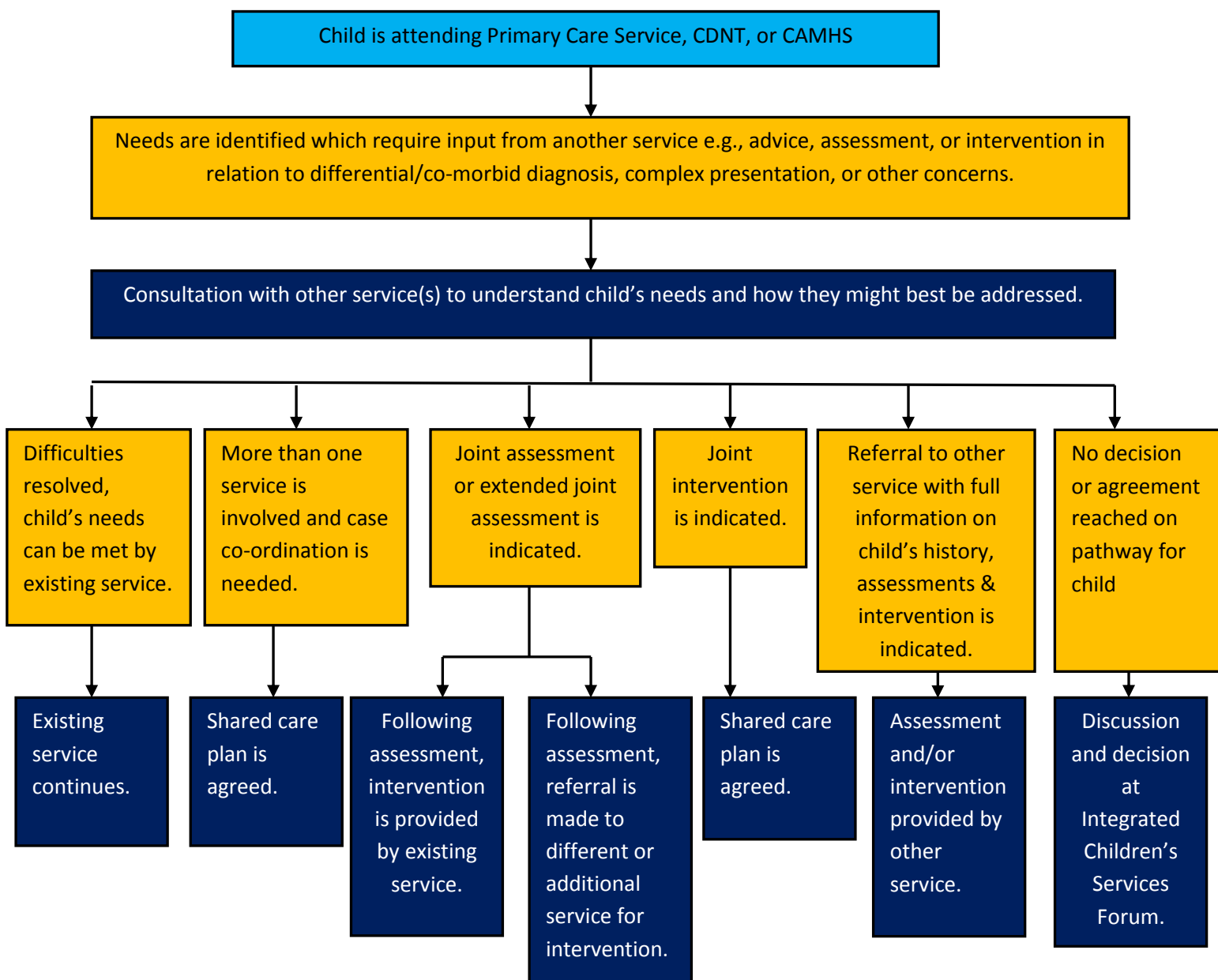
When it has been identified that a child's needs cannot be solely met by the service he or she is currently attending, consultation should be facilitated with other services to agree the best approach for the child. A number of options may result from this consultation:

- a) Advice and consultation may lead to a resolution of the issues and the current service can meet the child's needs
- b) Joint assessment may be indicated when presenting concerns or initial assessment indicate that there is a significant possibility of differential or co-morbid diagnosis of disability and/or mental health conditions.
 - 1. Joint assessment involves clinicians from two or more services conducting the assessment together bringing their combined expertise. This contribution of direct knowledge is very valuable, saves time, avoids the same information being sought repeatedly from the family and reassures the family that concerns are being heard. Joint assessment will be most effective if flexibility is agreed in relation to waiting lists to facilitate joint assessment in some cases.
 - 2. Extended joint assessment over a period of time may be required in order to come to conclusions as to the child's needs and/or diagnosis, and the best approach to meeting their needs. Services need to outline the timeline for the extended joint assessment, the frequency of review, and clearly identify roles and responsibilities in the joint assessment and resulting care plan.
- c) Joint intervention and/or shared care may be required. Roles and responsibilities of each service in supporting the child need to be clearly outlined and agreed, including which service has lead responsibility for coordination of care and what are the responsibilities of other services. Professionals will agree locally on the

process to ensure that relevant and key information is communicated to the appropriate personnel in a safe, timely and effective manner

- An example of collaboration and joint working is the practice of offering places on relevant groups for children or for parents to those attending other services in the area. The child remains the responsibility of the service they are attending, but the child/family benefits and it is a good use of overall resources in the area. Information regarding groups should be made available across services in order to enhance opportunities for sharing access to such resources.
- d) Agreement may be reached that another service is more appropriate to meet the child's needs and a referral with full information on the child's history, assessments and interventions is processed in the usual way. Responsibility for service provision resides with the service which is appropriate to meet the child's needs. However, if the child is on a waiting list in the receiving service, the referring service may continue to provide support for the child and family on a case by case basis for an agreed period of time.
- e) Coordination of services may be necessary if a child receives input from several service providers, including non-statutory services, educational support services, child welfare, and other service providers. It will be the responsibility of the lead provider to coordinate communication with all services which support the child.
- f) In some cases, no agreement is reached as to joint working or the most appropriate service and this may be put forward for broader discussion and decision at the Integrated Children's Services Forum by any of the services involved.

Diagram 3 - Consultation and Joint Working



Light blue = Situation or concern
 Orange = Service judgment/decision
 Dark blue = Service action

10 Communications

10.1 Clear and professional standards of communication enhance joint working. Professionals involved in joint working will determine the processes and protocols required to ensure effective communication. These will be based on existing local arrangements/systems and take cognisance of other regional or national requirements. Information handling policies and Data Protection regulations will be adopted under agreed terms of reference to support this protocol in each local area.

Referrals between professionals will be acknowledged and engagement/ response/ decision will commence within agreed timelines from receipt of the referral.

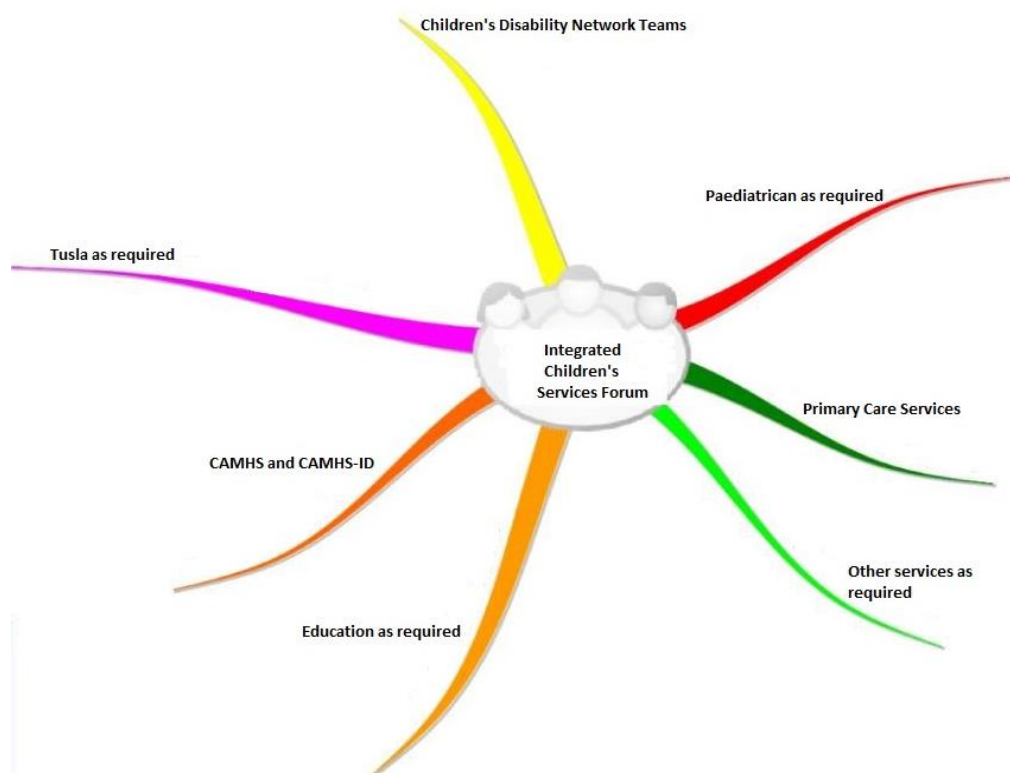
10.2 When referrals are made or joint working has been agreed, with parents' consent reports and comprehensive information on history of the child's difficulties and assessment and interventions must be shared. Reports should be comprehensive, explaining how the opinion or diagnosis was reached and show clear reasoning for conclusions and recommendations.

10.3 Each service will ensure that the highest professional standards are maintained in relation to confidentiality and any information sharing will have the appropriate informed consent. In this regard, all relevant personnel will be cognisant of obligations in relation to freedom of information and data protection.

11.0 Integrated Children's Services Forum

11.1 The Integrated Children's Services Forum will provide a formal, regular mechanism for services to meet and discuss individual children whose needs are not clear or who require some level of joint assessment or intervention and for whom direct consultation between the relevant services has not led to a decision on the best arrangement for the child. This forum will be empowered to call for inter-agency conferences and a joint plan for the child. Geographic area and frequency of meetings for the ICSF should be decided by the Chief Officer taking into account density of population, distances to travel to meetings etc.

Diagram 4 Integrated Children's Services Forum



11.2 Suggested Terms of Reference

The purpose of the Integrated Children's Services Forum (ICSF) is to ensure a coordinated and flexible approach to the delivery of services to children and their families based on need. The ICSF will:

- Develop a shared understanding of the child's presenting needs
- Assist the process of meeting the service requirements of children /families based on their needs rather than based on current service arrangements /thresholds.
- Make recommendations for shared care provision i.e. joint working across services where pathways or level of service is not clear.
- Act as a clinical decision making forum to ensure seamless access to and between agencies and services, using standardized criteria.
- Act as a decision making forum for referrals of children where pathways or level of service is not clear

- Make the best use of available resources to meet the needs of children and their families
- Provide an opportunity to highlight those individuals in need of services post 18 years of age and inform services of budgetary provision and resources required in advance.

11.3 Chairperson

The Chairperson for the ICSF is agreed and given authority and mandate by the Chief Officer and should be at General Manager level. Depending on the geography or size of the CHO there may be need for a number of ICSFs across the CHO and the duty may need to be shared between General Managers.

The Chairperson's role is:-

- To review and prioritise cases prior to consideration at the Forum.
- To seek additional information prior to submission to the Forum.
- To facilitate agreement and generate decisions in the best interests of the child.
- To be impartial irrespective of service background.
- To be rotated between Primary Care, Disabilities and CAMHS.

It is expected that agreement will be reached by the Forum on delivery of the most appropriate service(s) for each child. In the event that agreement cannot be reached the Chairperson must escalate the issue to the CHO senior management.

11.4 Membership

- Representatives of Primary Care Services
- Representatives of Disability Services
- Representatives of Child and Adolescent Mental Health Services (CAMHS) and CAMHS-ID
- Representatives of other services as required in line with the child's needs

All members of the Forum must have the relevant skills and experience to contribute effectively and must have the authority to make decisions on behalf of their service/agency.

Each service involved gives their representative authority to discuss cases and make clinical decisions on behalf of their service.

11.5 Working Arrangements

- Referral Criteria to ICSF
 - Children have already been referred to Primary Care, Disabilities or CAMHS and agreement has not been reached on service provision (see diagrams 2 and 3)

- Core Referral Data

In addition to the above criteria, referrals must be accompanied by evidence of the following:

 - All available relevant referral information and reports
 - The full procedure according to national and local policy for deciding the most appropriate service for the child has been followed.
 - The lead service/discipline making the referral should complete a chronology of events in order to present the case in the most effective manner possible and should attend the meeting of the Forum when this child is discussed.
 - The case has been discussed with relevant service manager/s prior to referral to ensure that all options have been explored based on the information available.

Note: Referral to and the process of waiting for the outcome of the ICSF should not impact on ongoing case management practices within and between disciplines.

11.6 Decision Making at the ICSF

The task of the ICSF is to make a decision in relation to the most appropriate service and/or the combination of services for an individual child based on information available and discussion with the referring clinician(s). Agreement may be made at the ICSF to exercise a degree of flexibility and cross-service collaboration in the interests of meeting the needs of the child and family.

11.7 Shared Care

When the ICSF decides that a child's needs will best be met under a shared care arrangement between services, a plan for shared care must be formulated to include details of:

- Services/teams involved
- Service/team with lead responsibility
- Lead professional whose role is to co-ordinate the pathway and bring any issues back to the ICSF for resolution
- Period of time this arrangement will be in place with timeline for review
- Names of members of staff in each service involved with the child and family
- Timeline for meetings of staff and responsibility for calling such meetings
- Development of individualised plan with parents and child (as appropriate to their age and understanding) and regular review of the plan as long as the shared care arrangement is in place

The individualised care plan should clearly show which service is dealing with each part of the intervention(s) and the actual intervention/service being provided. Consideration will be given to which professional/ service provider will be the long term care provider and a decision will be made in this regard. As agreed with the lead service, all professions and agencies are obliged to remain involved in the management of the case and to actively contribute to the required service solutions.

11.8 Management of costs

At the individual client level, interventions will be provided from existing resources and all services identified in the individualised care plan will make provision for the service within the allocation of their resources.

Where significant additional resources are required and needs cannot be met within existing resources, and alternatives have been explored, practitioners can refer the case through their respective line management structures to relevant Heads of Service for resolution. A business case must be provided to the appropriate manager at CHO level with details of the issues, actions to date, options and costings where appropriate, and signed by all relevant parties. Where additional funding requirements cannot be met at this level, further escalation may be required by the Head of Service or Chief Officer.

12.0 Resolution process

In situations where differences arise in relation to the management of a case and a local joint decision cannot be agreed, the practitioners from the different services must make every effort to resolve them so that appropriate interventions can proceed. Where this cannot be agreed, the matter must be escalated by the Chair of the ICSF to the relevant Heads of Service(s).

13.0 Implementation Plan

The Chief Officers of each CHO will take responsibility to implement this protocol at operational level. In order to effectively implement this protocol into everyday practice staff from Primary Care, Disability and Child and Adolescent Mental Health Services must be made fully aware of its purpose. A roll-out implementation plan for this protocol will be developed by each CHO Management Team in consultation with both local management and staff. A joint national oversight group will be convened with an agreed work plan to oversee the implementation of the protocol.

14.0 Evaluation and Audit

The implementation of this protocol and its operational success, including the identification of any gaps in services, will be audited and evaluated by the Chief Officers.

Signed: _____ Date: _____

Signed: _____ Date: _____

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