



**National Policy on Discharge/Closure and Transfer from Children's
Disability Network Teams Revised 9.10.17**

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1.0 Policy Statement

This policy is developed by the Access Criteria Working Group convened under the 'Progressing Disability Services for Children and Young People' programme.

1.1 Terms of Reference of the Access Criteria Working Group

To advise on a national policy for all Children's Disability Network Teams (CDNTs) on access to services.

1.2 Objectives of the Progressing Disability Services for Children and Young People programme

- One clear pathway to services for all children with disabilities according to need
- Effective teams working in partnership with parents
- Resources used to the greatest benefit for all children and families
- Health and education working together to support children achieve their potential

1.3 The principles of the programme in relation to access to services are as follows:

- ❖ Equity of access to services according to needs rather than to diagnosis
- ❖ Family centred services
- ❖ Evidence based best practice
- ❖ Services accountable for outcomes for children and their families
- ❖ Consistency in service delivery across the country

1.4 Duty of Care

Duty of Care is defined as taking responsible care to avoid any acts or omissions which could reasonably be foreseen and would be likely to cause injury. In processing referrals and offering services the interests and welfare of the child should be paramount at all times. From the time of receipt of referral the service has a duty of care to the child.

When a child and family have been offered services or the child's name placed on a waiting list, services have a duty of care to provide a service, be in regular contact and keep the parents/guardians informed of their status. This duty and responsibility continues until the child is discharged from the service.

If service users are given the status of inactive or dormant the service still has a duty to be actively involved and to regularly review the child's needs. If no intervention or review is needed, offered or accepted, services have a duty of care to discharge the child or refer onwards if appropriate. Parents/guardians should be informed that a re-referral may be made.

1.5 Relevant policies and programme guidance documents

- National Policy on Access to Services for Children and Young People with Disability and Developmental Delay 2016
- National Policy on Prioritisation of Referrals to Children's Disability Network Teams 2016
- Interim Standards for Children's Disability Network Teams 2015

2 Policy Purpose

This policy provides a national consistent, equitable method for the management of the discharge and transfer of services for a child from a CDNT.

3 Scope of the Policy

This policy applies to management and staff in all Children's Disability Network Teams.

4 Roles and Responsibility

It is the responsibility of each Community Healthcare Organisation (CHO) and governance group for children's disability services to oversee the implementation of this policy at management and team level and to monitor its operation.

5 Procedure

5.1 Reasons for Discharge/Closure

A service for a child may be finished because:

- The young person has reached the age of 18 years, or has completed second level school if later and service was extended to his or her 19th birthday to meet specific needs
- The child has attained the expected outcomes of service interventions or has made significant gains and no longer requires intervention
- Discharge is requested by the parents, or by the young person if over the age of 16 years
- The family has not brought their child for services on a persistent and ongoing basis despite efforts by the team to engage and facilitate them

5.2 Missed appointments

There must be a written policy on missed appointments and parents must be made aware of the policy from the time they commence with the service. Missed appointments include those where the child is not brought and those where appointments are cancelled.

When lack of attendance is shown to be an issue every effort must be made by the team to engage with the family, be aware of any vulnerabilities such as communication or literacy difficulties, and exceptional personal circumstances such as illness or bereavement, and be as flexible as possible in arranging appointments.

If a child is to be discharged because of ongoing non-attendance, despite all possible measures to facilitate the family, and there are concerns about the child's health and/or welfare, consideration must be given to referral to Tusla, the Child and Family Agency, and the parents/guardians must be informed of such referral.

5.3 Process for discharge/closure

A proposed timeframe for discharge/closure will be discussed in advance with the family.

Discharge/closure summary report

At the time of discharge or closure each young person/family will receive a report which summarises the interventions and progress achieved, and makes any recommendations on future services and onward referrals where appropriate. A copy of the summary is sent to the GP, referrer and relevant others with permission.

It must be clearly stated in the summary report that the intervention is at an end and that if the child's condition or developmental progress gives any cause for concern, the service should be contacted to seek advice or request a review and that children who are re-referred will be prioritised according to the date of their original referral to the team, not the date of re-referral.

5.4 Transfer of Services

A child may be transferred to another service because

- The child has commenced in primary school and services are to be transferred from the Early Intervention to the School Age Team
- The child has moved address and no longer lives in the team's geographic area so is transferring to another team
- The child's needs have changed and could be met by Primary Care Services

A plan for the smooth transition to another service should be developed and agreed with the family. In the case of transfer from Early Intervention to School Age Team this is predictable and should be planned well in advance, with the aim to make it as seamless as possible for children and families.

The team/service must obtain permission from the parents/guardians/young person to release information in order to make a transfer of services. A summary report of interventions and progress achieved to date and all relevant information will be sent to the new service for the child and family, copied as appropriate to the GP, referrer and relevant others.

If a child's service is transferred between CDNTs, either due to change of address or to a move from Early Intervention Team to School Age Team, the new team must take the date of the original referral to a CDNT as the date he/she was referred, not the date of transfer.

If a child is re-referred subsequent to discharge from a CDNT the team must take the date of the original referral to the team as the date he/she was referred, not the date of re-referral.

5.5 Record keeping

In all instances of discharge, closure or transfer there needs to be a clear procedure for ensuring:

- Summary report is completed and sent to relevant persons
- Date of discharge/closure or transfer is documented
- All records are complete, collected and archived

6 Implementation Plan

This policy will be implemented in conjunction with the National Policy on Access to Services for Children and Young People with Disability and Developmental Delay and the National Policy on Prioritisation of Referrals to Children's Disability Network Teams.

7 Evaluation

The operation of this policy will be reviewed and evaluated at national and at CHO level for effectiveness and consistency within one year of commencement of implementation and thereafter at a minimum of every two years.