TO IMPROVE THE ROUTINE CARE PROVIDED TO PATIENTS AGED 0-24 RECEIVING LONG-TERM VENTILATION:

NATIONALLY

Ensure **SERVICE PLANNING/COMMISSIONING OF INTEGRATED CARE PATHWAYS** for long-term ventilation services includes formal contract arrangements and local standardisation where possible. These arrangements should bridge child and adult health as well as social care services, respite care and any other partnerships relevant to the local network.

LOCALLY

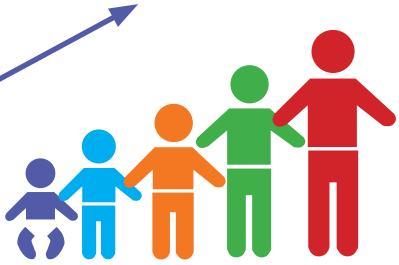
The **MULTIDISCIPLINARY TEAM** should work across community and hospital networks and include a specialist in tracheostomy care where applicable

Personalised **EMERGENCY HEALTHCARE PLANS** should be reviewed annually and after hospital admissions, and form part of the hand-held record

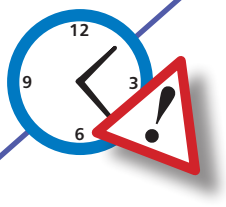
ALL people on long-term ventilation should have access to **AGE-APPROPRIATE EMERGENCY CARE** by a team with the relevant competencies

The **FREQUENCY OF CLINICAL REVIEW** should be optimised for all patients at an increased risk of admission

ROUTINE CARE

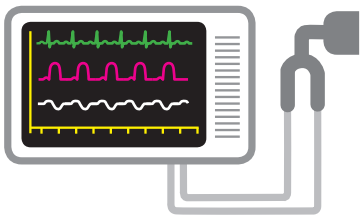


TRANSITION PLANNING should include an identifiable clinical and executive lead, and form part of an integrated care pathway



DISCHARGE ARRANGEMENTS for people established on LTV who are admitted to hospital should:

- Commence on admission
- Be clearly documented
- Involve the usual LTV team
- Document any changes to usual care



All patients should receive a **GOOD LEVEL OF VENTILATION CARE** when admitted to hospital for any reason by:

- Undertaking clinical and respiratory assessment
- Undertake routine vital signs monitoring
- Involve the usual LTV team
- Identify clinical leadership of ventilation care

NCEPOD