



NEWHAM LOCAL
SAFEGUARDING CHILDREN
BOARD



Discharge and Safety Planning Protocol for Children and Young People Admitted to Hospital

June 2018

1. Introduction

1.1 Parties to the Protocol

Bart's Health NHS Trust

Newham Children's Social Care, LBN

NHS East London Foundation Trust

1.2 Purpose and Scope

The purpose of this protocol is to support multi-agency practitioners to make appropriate arrangements which support the safe and timely discharge of children and young people under 18 years of age.

The protocol is intended to ensure that all practitioners are clear about the steps to take to ensure that no child is discharged from hospital into an unsafe environment, where their health or well-being may be compromised or where further significant harm could occur.

The protocol applies to children and young people who require a multi-agency response to address their needs. A multi-agency response may be required due to:

- Serious or complex mental health needs requiring hospital admission
- Self-harm or attempted suicide; or have expressed an intention to do either
- Other health needs and there are safeguarding and/or other welfare concerns about the child/young person

Safeguarding and other welfare concerns cover situations where:

- In cases where abuse, exploitation or neglect is known prior to admission, and this is recent or current, it would be expected that these cases have an allocated social worker)
- The child/young person is looked after
- Abuse, exploitation or neglect comes to light or is suspected during the hospital admission
- Parent/carer understanding and concern for their child is lacking
- Ward staff raise concerns about the parent/child interaction
- The child/young person says they do not want to return home

This is not an exhaustive list and professionals should apply their professional judgement and consult with their named safeguarding leads if they have any concerns at all about a child/young person.

1.3 Principles

1. Any child or young person, who self-harms or expresses thoughts of self-harm or suicide, must be taken seriously and appropriate help and intervention,

should be offered at the earliest point. Any practitioner, who is made aware that a child or young person has self-harmed, or is contemplating this or suicide, should talk with the child or young person without delay.

2. Most children who have been admitted with mental health needs will need on-going community care for a period of time after discharge. Follow up services for the young person's mental health services could include, outreach sessions, liaison with local services, and outpatient therapy sessions and will be determined by the local CAMHS service following assessment.
3. Discharge planning is an essential part of care management in any hospital setting. It ensures that health and social care systems are proactive in supporting individuals and their families in the community. It needs to start early to anticipate problems, put appropriate support in place and agree service provision. Consideration should be given to the wider environment the child will be returning to, including siblings and other members of the household.
4. Children should not remain in hospital once they are well enough to leave. However, it is essential that when a child is in hospital and there are safeguarding concerns about the child, effective multi-agency planning between key professionals working with the child is undertaken before the child is discharged from hospital. Where there are safeguarding concerns, a referral must be made to Newham Children's Social Care.
5. All agencies have a duty to share information and a joint responsibility to work together to protect children and promote their wellbeing and safety. Referrals to Children's Social Care must be made in accordance with the levels of need set out in the Newham Pathway for Help and Support and clearly indicate whether the referral is for support or protection.

1.4 Linked Policies and Procedures

The protocol should be read in conjunction with:

- The London Child Protection Procedures
- The Barts Health Psychiatric Problems in Children Flow Chart
- The Barts Health Safeguarding Children Policy
- NHS East London Foundation Trust Child Protection Policy
- Newham Pathway for Help and Support
- Newham LSCB Escalation Policy

2. Roles and responsibilities of the parties to this protocol

The protocol applies to all departments and wards where children are being treated and to all teams in ELFT and CSC that are working with children, including out of hours teams.

2.1 Acute Hospital Practitioners

- Assessment of the child or young person should include a full assessment of the family, their social situation and any safeguarding issues.
- Ensure that practitioners undertake environmental assessments to ensure that healthcare settings are safe for people who have self-harmed and to reduce self-harm while in the healthcare setting.
- Children under 16 should be assessed to establish whether they have competence to make a particular decision at the time it needs to be made. The test for children under 16 is determined by considering whether they are “**Gillick competent**”.
- Follow the Hospital Safeguarding Children Procedures and **where necessary** make appropriate referrals to Children’s Social Care (CSC) indicating whether the referral is for support or protection. A discussion should take place with the practitioner from Child and Adolescent Mental Health services (CAMHS), who may contribute to the referral or make a direct referral to CSC if the hospital has not already completed this. This should be clearly documented.
- The referral to Children’s Social Care (CSC) should include information about the back ground history and family circumstances, the community context and the specific concerns about the current circumstances, if available.
- If a child is already known to CSC with ongoing child protection or safeguarding concerns, there must be a discussion with the allocated social worker or emergency duty team and appropriate plans made prior to discharge (which should include a discharge planning meeting)
- The admitted patient is the responsibility of the medical team and the responsibility for discharge lies with the responsible Medical Consultant.
- Permission for discharge should only be provided once the Consultant confirms that there is a clear, agreed discharge plan in place and receives confirmation that the child is being discharged or transferred to a place of safety. Permission for discharge should be documented in the child’s medical records
- Where there are safeguarding concerns, the child should not be discharged without a discharge planning meeting and/or the agreement of the allocated social worker or the emergency duty team and, where appropriate, other multi-agency partners such as the Police.
- Discharge letters which detail the discharge plan should be copied, with the patient’s/parent’s/carer’s knowledge, to the relevant health and social care children’s professionals involved with the family, with clearly documented plans for further follow up or investigations.
- If the child is discharged to an address other than their home address, or into the care of someone other than their parent, this must be clearly recorded in the child’s records.

- The Children and Young People Safeguarding Team for the NHS Trust where the child has been admitted must be informed.

2.2 Children Social Care

The child or young person may be a Child in Need of services (s17 of the Children Act 1989) which could take the form of an early help assessment or child in need assessment or they may be likely to suffer significant harm, which requires child protection services under s47 of the Children Act 1989. All referrals should be made to Triage who will determine the level of response by processing information through the multi-agency safeguarding hub. Based on the level of need there are likely to be one of 4 outcomes:

- I) Case passed to universal services for Early Help Support
- II) Case allocated to Families First for targeted support
- III) Case allocated for child in need assessment
- IV) Case allocated for child protection enquiry

Out of hours at weekends, evenings and Bank Holidays the Emergency Duty Social Worker will provide the CSC response.

- A Triage Practice Leader will respond to all referrals within 24 hours of the receipt of referral and on the same day for urgent, high risk cases;
- Hold a telephone discussion with the referrer
- Follow the London Child Protection Procedures and Newham Pathway for Help and Support.
- Feedback results of enquiries to referrer and advice of actions, Early Help, s17 or s47.
- Should the referral progress s47, the allocated social worker will become the lead professional. and arrange a multi-agency strategy meeting. If the child already has an allocated Social Worker, Triage will pass the referral immediately to them.
- In cases that progress through a child in need pathway, the allocated social worker will usually become the lead professional, unless it is more appropriate for a mental health professional to hold this role
- Not all cases involving complex mental health will require a social worker and cases may be stepped down on completion of the s47 enquiry or child in need assessment

The allocated social worker will:

- Meet with the child/young person and parent/carers to start a child in need assessment and develop a safety plan. This assessment must be completed within 45 working days and in urgent cases this will be completed more quickly, especially if discharge is imminent.

- Initiate a section 47 child protection enquiry (if threshold is met). As part of this enquiry, CSC will arrange a multi-agency strategy meeting and invite the police, health and education to attend. The section 47 strategy meeting will be chaired by a CSC Practice Leader. The social worker will complete the section 47 enquiry within 15 working days
- Attend the Discharge Planning Meeting in cases where there are safeguarding concerns and a referral has been made to CSC
- If the child/young person cannot be safely discharged to their own home, an appropriate place for discharge will be discussed in conjunction with CAMHS. Further to this, if it is deemed unsafe for the young person to return home, social care will discuss the need for an alternative placement with the Head of Service and ensure an appropriate multi-agency safety plan.

2.3 Child and Adolescent Mental Health Services Practitioners

- All children placed on a general hospital or paediatric ward will be assessed by CAMHS within 4 hours if admitted on the same day or the following morning if admitted in the evening.
- A **Mental Capacity Assessment (MCA)** may be required for young people aged 16-18 years.
- Record their written assessment onto RIO and share this assessment with the ward staff to develop a joint care plan. Any risks should be clearly identified and recorded.
- Meet with parent/carers to develop a risk management plan and arrange a follow up appointment in the community and/or other further treatment
- Ensure a daily discussion with the acute ward about each young person on the acute wards and support decision making regarding the safe discharge of children admitted with mental health needs from acute hospital wards
- Agree to complete a referral to CSC Triage, in collaboration with the admitting medical team, if there are safeguarding concerns (see page 1) attaching their clinical assessment and any other relevant information and reports to inform assessment and decision making. Contact will be via:
 - An on-line referral to Triage (if one has not already been completed by the medical team)
 - Contacting and updating Triage if the hospital have already made a referral and the case is not yet allocated to a social worker
- Follow up any failed appointments after discharge

3.0 The Discharge Planning Process

The hospital is the lead agency for this process (see page 3) and not all admissions will require a Discharge Planning Meeting (DPM). However, a DPM must be convened whenever there are safeguarding concerns (see page 1) and/or other complexities that require a multi-agency co-ordinated approach.

3.1 Agency attendance at the DPM

This will vary depending on the reasons for admission and needs of the young person. At a minimum, it will involve the responsible **Medical Consultant and or Duty Consultant or their delegate; Ward Nursing Staff and if mental health and/or self harm is involved, a CAMHS Practitioner**. If CFCS cannot attend the DPM, they will dial into the meeting.

Where there are safeguarding concerns and/or the case is already open to a social worker they or their Practice Leader will attend the DPM and the Practice Leader will chair this meeting.

Where possible and appropriate, young people and their parent/carers should be invited to the meeting. If they cannot attend, their views should be sought and shared at the meeting.

3.2 Convening the Discharge Planning meeting

This should take place in a timely manner and within 24 hours prior to discharge, if there is a need to put in place arrangements to support or safeguard the child or young person. Key to ensuring an effective discharge process is timeliness of response, collaborative working and information.

Discharging young people where there are safeguarding concerns at the weekend or bank holidays should be avoided.

- The hospital convene the DPM
- A separate professionals meeting may be required in some cases e.g. where there are threshold issues; discharge is not imminent
- For cases meeting the child protection threshold, CSC will convene a Child Protection Strategy meeting which may precede or follow the DPM (see References page 10)
- Ideally all these functions should be fulfilled within a single meeting

3.3 Agenda for the DPM

The meeting will be initiated by the hospital. The hospital will chair the meeting, record and circulate the discharge plan (see Appendix 1). In cases where Children's Social Care are involved they can hold the chairing responsibility.

The DPM will address:

- Background and reasons for admission
- Outcome of assessments
- Voice of child and their lived in experience
- Develop the discharge plan

3.4 The discharge plan will specify

- The identified risks, triggers and warning signs
- Protective factors
- Treatment and support plan with timescales
- Outcomes to be achieved
- Details of follow up appointments and visits and who will have contact within 48 hours of discharge
- Arrangements for weekend and school holiday periods
- Status and ownership of the plan / Interface with other plans
- Details of lead professional(s)
- Contingency plan and a crisis/ contingency plan
- Agreement/any areas of disagreement
- Follow up meetings and who will attend these.
- Follow up meetings may need to include other agencies that will be working with the child/young person such as their school or college; youth worker; school nurse or GP;

3.5 The Discharge plan should be documented on the agreed template (see Appendix 1) and cover the following areas: An agreed multi-agency discharge plan will set out arrangements for the care and safety of the child following discharge from hospital into the community and will include actions; timescales and responsibility for actions; Emergency planning for the child and family. Details of the child's GP. If they are not registered this must be organised before the child leaves hospital.

- Additional medical investigations requested including timescales for completion
- Mental Health follow up
- Documentation of any legal orders arising from the admission (with copies filed if available)
- Agreement about what information should be shared with parents/carers and other professionals, e.g. school staff, and how and when this information will be shared.
- Any further meetings required or other review dates.
- The lead agency for the DPM is responsible for recording the discharge plan circulating a copy of the discharge plan within 3 working days of the meeting (CSC will be responsible for cases allocated to a social worker)
- The DPM meeting should agree who this will go to including the GP.

A copy of the Discharge Planning meeting must be placed in the child's medical notes and the agency records of any other parties to this meeting

4.0 Escalation/Conflict Resolution

Any practitioner who has concerns regarding the application of this protocol or encounters conflict which they are unable to resolve with regard to the care and treatment of a child/ young person within the scope of this protocol should:

- I) Raise initial problems with a team manager/clinical lead/ or on call Manager out of Hours.
- II) If it cannot be resolved then the manager/clinical lead will pass the information on to a Director or Senior Manager.

If problems still persist and a resolution has not been sought then this should be escalated to the LSCB by the agency safeguarding lead.

Appendix 1 Discharge Planning Meeting Template

To be completed and circulated by the Meeting Chair

Child/Young Person's Full Name		Details of Parent/Carers and who has Parental Responsibility
D.O.B		NHS number
Background and reason for admission:		
Details of any previous admissions:		
Date of this meeting and who is chairing		
Dates of any previous meetings since admission/outcome		
Names of those attending		
Title		Email and phone contact
Outcome of Assessment(s)		
Hospital		
CAMHS		
CSC		
Other		
Voice of the child/young person and their lived-in experience		
Identified Risks, Triggers and Warning Signs		
Protective Factors		

Treatment and Support plan: (to include medication, any additional medical or social investigations required, direct work with young person and other family members, safety measures)

Outcomes to be achieved with the child/young person	What will be provided	Who is responsible	Timescales

Are any specific arrangements required for weekend and holiday periods?

Details of follow up appointments and visits (timeframe and by whom)

Who will have contact with the young person and their carers within 48 hours of discharge?

Status and ownership of the plan / Interface with other plans

Names of Lead Professional(s)

Are there any areas of disagreement to the discharge plan? If yes, how will these be resolved?

Contingency plan: specify what will happen if the plan is not followed

Follow up meeting(s) Identify who needs to be invited to attend. E.g school or college; youth worker; school nurse or GP;	Date and Venue	Who will arrange

5.0 References

a) NICE guidance for Self – Harm. The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care .Online available at: <https://www.nice.org.uk/guidance/cg16>

The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. Sections: 1.9.1.3. And 1.9.1.5 and 1.9.1.6.for under 16years and 1.8.1.3, 1.8.1.4 and 1.8.1.5.

b) Mental Capacity Act Code of Practice (2005) .Online Available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224660/Mental_Capacity_Act_code_of_practice.pdf

c) Mental Health Act Code of Practice (1983). Online available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/HA_Code_of_Practice.PDF

d) London Child Protection Procedures and Practice Guidance Updated 2nd October 2017 <http://www.londoncp.co.uk/>

e)_NICE Guidance: Transition between inpatient mental health settings and community or care home settings <https://www.nice.org.uk/guidance/qs159>

Child Protection Section 47 Enquiries and Strategy Meetings

Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, there should be a strategy meeting / discussion. A strategy meeting / discussion should be used to

- Share available information;
- Agree the conduct and timing of any criminal investigation;
- Decide whether an assessment under **s47 of the Children Act 1989** (s47 enquiries) should be initiated, or continued if it has already begun;
- Consider the assessment and the action points, if already in place;
- Plan how the s47 enquiry should be undertaken (if one is to be initiated), including the need for medical treatment, and who will carry out what actions, by when and for what purpose;
- Agree what action is required immediately to safeguard and promote the welfare of the child, and / or provide interim services and support. If the child is in hospital, decisions should also be made about how to secure the safe discharge of the child;
- Determine what information from the strategy meeting / discussion will be shared with the family, unless such information sharing may place a child at increased risk of significant harm or jeopardise police investigations into any alleged offence/s;
- Determine if legal action is required.

http://www.londoncp.co.uk/chapters/chi_prot_eng.html#section

6. Glossary

Gillick Competence

People aged 16 or over are entitled to consent to their own treatment, and this can only be overruled in exceptional circumstances.

Like adults, young people (aged 16 or 17) are presumed to have sufficient capacity to decide on their own medical treatment, unless there's significant evidence to suggest otherwise. Children under the age of 16 can consent to their own treatment if they're believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment. This is known as being "Fraser competent".

<https://www.nhs.uk/conditions/consent-to-treatment/children/>

Lead Professional

The person responsible for co-ordinating the actions identified in the assessment process and being a single point of contact for children with additional needs being supported by more than one practitioner. www.everychildmatters.gov.uk/leadprofessional

Care Programme Approach

Care programme approach (CPA) is an approach that is used in specialist mental health services to assess needs and then plan, implement and evaluate the care that service users receive.

The CPA is a framework that describes the process of assessing, planning, reviewing and co-ordinating the range of treatment, care and support required for the best positive outcome of the Child and Young Person within the Specialist provision.

The purpose of the CPA is to ensure that service users are at the heart of their care, receive clear treatment pathway and that there is a clear robust line of accountability for their package of care.

An approach such as CPA can particularly add value for those children and young people with more complex needs, such as those which need help from specialist multi-disciplinary Specialist Mental Health Services for Children and Young People (CAMHS). The value of CPA in enabling transparency of care and treatment and promoting accountability of clinicians needs to be enhanced by linking with other planning and assessment frameworks.