Practice Guidance and Care Pathway for Children and Young People Admitted or at Risk of Admission to Psychiatric In-Patient Units

CONTENTS **PAGE**

Introduction

This guidance outlines expectations in relation to all children/young people, who are admitted to Psychiatric In-patient Units and those at risk of admission. For those admitted it places particular emphasis on the importance of planning for discharge. This practice guidance has been agreed by the Birmingham Clinical Commissioning Groups and Birmingham Children's Trust. The guidance is endorsed by NHS England, as commissioners of inpatient child and adolescent psychiatric care, as best practice in partnership working to ensure that the needs of the child/young person are met and there is good multi-agency discharge planning when the young person is becoming ready to leave hospital.

Whilst the numbers of children/young people admitted or at risk of admission to Psychiatric In-Patient Units are relatively low, these are clearly very significant experiences in a child/young person's life. All agencies need to communicate and co-ordinate the planning and decision making for each child/young person in such situations. This is particularly important if the child/young person is receiving support from a Local Authority other than the one where the unit is located. If a child or young person admitted to a Psychiatric In-Patient Unit does not ordinarily live in Birmingham then the unit must make contact with children services in the local authority within which the young person is ordinarily resident. Any disputes or disagreements must be resolved using the dispute resolution procedures of the authority within which the young person is ordinarily resident.

Guiding Principles

This practice guidance operates under the guiding principles as outlined in Chapter One of the Mental Health Act Code of Practice.[1] Its five overarching principles are:

1. Least restrictive option and maximising independence
2. Empowerment and involvement
3. Respect and dignity
4. Purpose and effectiveness
5. Efficiency and equity

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF Page 22

Purpose

This guidance is intended to enable co-ordinated and appropriate support to be provided to all children who are admitted to In Patient Psychiatric Units or at risk of admission and it follows recommendations from Serious Case Reviews.

Information Sharing

This guidance reflects data sharing agreements and protocols between Health CCGs and Health Providers and Birmingham Children's Trust.

Section 1: Working Together to Avoid Admission to Hospital

1.1 In line with the overarching principles outlined in the introduction and in particular the need to pursue the least restrictive option and maximising independence, all parties will look to avoid admission to hospital unless this is agreed as the only way to address a young person's mental health issues.

1.2 Any child or young person who has learning disabilities, autism or both, who is at risk of admission due to the nature of their mental health needs, should first have a planned Community Care, Education and Treatment Review (CETR).[2] Liaison with the relevant school and with Birmingham Special Education Needs Advice and Referral Service (SENAR) will be essential in these cases but also in relation to other children and young people where their mental health needs are impacting on their education. General enquires to Birmingham SENAR can be made on 0121 303 5489 or 0121 303 4175.

1.3 Support for children and families in Birmingham are provided under the 'Right Help Right Time' Framework.[3] Children with 'moderate to severe mental health problems' come under the category in the Framework of children who have 'Complex/Significant Needs'. It is therefore recognised that these children have needs that are so significant they may need statutory social work intervention or highly specialist services to prevent significant harm or serious risks to their health or welfare.

1.4 Whether or not a Birmingham child or young person is known to the Birmingham Children's Trust can be established by contacting the Children's Advice and Support Service (CASS) by phone on 0121 303 1888 or making an enquiry by secure email[4] to cass@birminghamchildrenstrust.co.uk. If the child or young person does not have an allocated social worker or family support worker a referral can be made using the 'Request for Support' form.

[2] NHS England https://www.england.nhs.uk/learning-disabilities/ctr/care-education-and-treatment-reviews/
[3] Birmingham Safeguarding Children Board http://www.lscbbirmingham.org.uk/index.php/delivering-effective-support
[4] Go to https://reader.egress.com/ and click on 'Compose a Secure Email'

This can be found along on the Birmingham Safeguarding Board's website: http://www.lscbbirmingham.org.uk/index.php/safeguarding-referrals-item.
This can be sent to the CASS email address above. Those with access to a secure email account e.g. 'nhs.net' can send the referral securely on secure.cass@birmingham.gcsx.gov.uk. If the referral requires immediate attention please ring CASS on 0121-303-1888 and select option 2 and then option 2. The phone line is open Mon-Thurs 8.45am- 5.15 pm and Friday 8.45am-4.15pm. Outside these hours you can call the Emergency Duty Team on 0121 675 4806.

1.5 The immediate priority in all cases will be to establish whether there is a way the child or young person can be supported to remain in the care of a family member and looking at additional support to facilitate this.

1.6 If remaining with a family member does not appear possible there will need to be a multi-agency discussion to establish whether the child or young person's primary need is to have their mental health difficulty treated or their care needs addressed.

1.7 Where there is a dispute regarding admission to a psychiatric unit this can be escalated to Senior Lead Nurse Complex Care Pathway (Currently Emma Cooper ecooper7@nhs.net) and the appropriate Head of Service in Children's Services covering the young person's home address.

1.8 Where the need for admission is agreed but a bed is not available this will be escalated within the Birmingham Children's Trust to the Head of Service or Assistant Director and to Head of Mental Health and Programme of Care Lead NHS England Midlands and East (Currently Eric Pwamang eric.pwamang@nhs.net)

Section 2: Admission to Psychiatric In-Patient Units

2.1 On admission the legal status of the child/young person, the identity of who has parental responsibility and the nature of their involvement with the child/young person must be clarified and recorded in the clinical record. It is essential to identify any 'absent' parents and to consider their involvement and whether the child/young person is known to the Birmingham Children's Trust (see 1.4)

2.2 If the young person is already receiving a service from the Children's Trust they will be supported as either a Child in Need, a child who is the subject of a Child Protection Plan or a Child in Care. The process for each situation is set out under Section 4.

2.3 An initial formulation meeting should be held within ten working days of the child/ young person's admission. Where it is anticipated that discharge may occur earlier, the formulation / discharge planning meeting may be combined and held earlier and involve the young person's keyworker in the inpatient unit and chaired by a member of the multi-disciplinary team. The Care Programme Approach (CPA) Coordinator must attend.

2.4 Where the Children's Trust are involved, the named/allocated Social Worker will make it a priority to attend all CPA meetings/reviews including the formulation meeting and they are expected to be involved with the Clinical Psychiatric Team in joint decision making. Times of CPA meetings should be negotiated with invitees. Units should ensure Heads of Service and Team Managers are advised of routine times for ward reviews.

2.5 On admission it should be established whether or not the young person is on the roll of an educational provision. This educational provision will have responsibilities relating to the assessment and meeting of any special education needs (SEN) experienced by the young person. It is essential that any concerns regarding a young person's ability to resume their previous educational provision are raised as soon as possible, particularly where they may require residential schooling, in order to avoid the potential for delayed discharge. This should have been discussed at any CETR prior to admission.

The hospital educational lead should alert the relevant SENAR officer that the young person is admitted and liaise with the SENCo or Pastoral Lead from the young person's home school (see 1.2).

2.6 Statutory guidance for organisations which work with and support children and young people who have special educational needs or disabilities is provided in the Special Educational Needs and Disability Code of Practice[5]

2.7 The child/young person should have access to independent mental health advocacy. Where a young person has an existing advocate; this advocate should be invited to attend CPA Reviews and to continue to support the young person. Where a young person does not have an existing independent mental health advocate the named/allocated Social Worker and the CPA Co-ordinator should ensure advocacy is available. Post-discharge, advocacy will need to be addressed by the named/allocated Social Worker or the Independent Reviewing Officer if there is one.

2.8 For incidents involving allegations against staff or other service users consideration must be given to informing children's services and advice from the Health Trust's Head of Safeguarding should be sought.

2.9 Planning for discharge for all young people must commence on day one of admission. The CPA Discharge Planning Meeting must be held before the child/young person is discharged. The purpose of the meeting is to ensure that there is an appropriate multi-agency plan in place for the child/young person's discharge. (See Section 5.)

5 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/398815/SEND_Code_of_Practice_January_2015.pdf

Section 3: Children Not Open to the Children's Trust on Admission

3.1 Any child/young person admitted to an adolescent inpatient unit can be considered to be a Child in Need under the Children Act 1989.[6] They and or their parents have the right to request a Child in Need (CiN) assessment. There must always be a discussion with the young person and their family in relation to their agreement for making a referral to children's social care. The Unit should seek valid informed consent to notify the Children's Trust of the admission and to request a Child in Need assessment. On day one of admission consent to share information should be sought from the child/young person or, where the child does not have capacity, from an individual holding parental responsibility

3.2 A referral to the Children's Trust should always be made if:

a) A parent or a competent young person agree to the information about them being shared with the Children's Trust, e.g. where the parent or young person needs support to facilitate a discharge home to avoid admission into care, or

b) There are grounds for making a referral due to concerns that the child or young person is at risk of significant harm or another child in the household may be placed at risk if the young person is discharged home.

3.3 There may be cases where the young person and his/her parents have different views about a referral to the Children's Trust, and this needs to be determined based on the individual circumstances and the factors referred to above.

3.4 Where parents or a young person object to a referral being made to the Children's Trust and there are identified concerns about significant harm, a referral must proceed in the best interests of the young person as reflected in the Right Help Right Time guidance.[7]

3.5 Contact details for the Children's Trust can be found in paragraph 1.4.

[6] Children Act 1989 Section 17 (11) http://www.legislation.gov.uk/ukpga/1989/41/section/17
[7] Birmingham Safeguarding Children Board http://www.lscbbirmingham.org.uk/index.php/delivering-effective-support

3.6 On receipt of notification of admission, the Children's Trust will consider whether to undertake a Child in Need assessment and will attend CPA reviews and discharge planning meetings as appropriate. Where the Children's Trust decides not to undertake an assessment, a written explanation will be given to the referrer.

3.7 If a young person is entitled to Section 117 Aftercare on discharge the Children's Trust will have a duty to provide aftercare services if appropriate (see Section 6).

Section 4: Children Open to the Children's Trust on Admission

Children in Need

4.1 Consent should still be sought from the young person and / or their parents in order to notify the Children's Trust and make their allocated worker aware of their admission.

On receipt of notification of admission, the Children's Trust will review the existing Child in Need plan. A representative of the Children's Trust will make it a priority to attend CPA reviews and discharge planning meetings as appropriate for young people on the unit.

Children Who are Subject of a Child Protection Plan

4.2 If a child subject to a Child Protection Plan is admitted, the Children's Trust is to be advised with or without the consent of the young person or parent. The Social Worker will advise the Child Protection Conference Chair, who, along with the Core Group will consider whether a review/emergency Child Protection Conference should be convened. There is an expectation that the potential risks and likelihood of significant harm will be re-assessed in light of the young person's admission to the unit. The allocated Social Worker will update the Core Group on a weekly basis about the child/young person's progress and the planning. During this time the CPA or Key Worker should become a member of the Core Group.

4.3 For children subject to a Child Protection Plan the Core Group should update the Child Protection Plan, in consultation with the young person, parents and Chair, to reflect the needs of the child during and post admission.
The Child Protection Plan is to be made available to the CPA/Key Worker.

The CPA or Key Worker should attend a Review Child Protection Case Conference if required, and provide a report as per the Child Protection process.

The Social Worker will advise the School Nurse and other relevant professionals of the child/young person's admission.

Children in Care

4.4 A child or young person can accommodated by the local authority under a variety of legal provisions:

- Under a voluntary agreement with parental consent or with their own consent if aged 16 or 17 (Section 20 Children Act 1989).
- Subject to a care order imposed by the courts (Section 38 or 31 Children Act 1989).
- Subject to an Emergency Protection Order (Section 44 Children Act 1989)
- Remanded to local authority care (Section 21 Children Act 1989)

4.5 Where a child is in care, the Children in Care Designated Nurse of the CCG in which the unit is situated must be informed of the child/young person's admission by the young person's keyworker within the respective psychiatric unit. For Birmingham Children in Care this is:

Katy Willitts Designated Nurse Children In Care
Email: katy.willitts1@nhs.net
Tel: 0121 255 0640
Mobile: 07715 050951.

The Children in Care Designated Nurse will liaise with the relevant Designated Nurse where the child/young person originates.

4.6 An overall CPA and Care Plan should be agreed at the CPA meeting. Where the young person is a looked after child, the Children in Care Designated Nurse should be kept informed throughout a young person's admission and provided with minutes of Formulation Meetings and CPA Reviews by the Care Coordinator.

4.7 Minutes and copies of reports discussed in CPA meetings will be shared with the allocated Social Worker. In the event that the allocated Social Worker is unable to attend, minutes of the meeting and reports will be electronically emailed to secure (gcsx / nhs.net) email addresses as required.

4.8 On-going responsibility for the child/young person's health care remains with the originating CCG to coordinate as required *(as per admission form Appendix 1)*

4.9 For children in care, the named/allocated Social Worker must ensure that the Team Manager and Head of Service and the child/young person's Independent Reviewing Officer (IRO) are made aware of the child/young person's admission within 24 hours.

The IRO should always consider whether it is appropriate to convene a statutory review within 8 days of admission. They should record the reasons if a statutory review is not required. In many cases the formulation and CPA meetings will provide a sufficiently comprehensive plan.

4.10 If the young person is voluntarily accommodated under section 20 of the Children Act 1989, the child/young person's parents or carers should be involved in formulation or discharge meetings or CPA reviews unless the young person has capacity and declines their parents or carers involvement.

If the young person is the subject of an Interim or Full Care Order then the involvement of their parents in formulation or discharge meetings or CPA reviews will be at the discretion of the social worker and team manager.

4.11 As with all children and young people planning for discharge must commence from day one of admission. Including immediate exploration of any additional support required within the community / placement.

4.12 The Independent Reviewing Officer should have access to the CPA Plan via the named/allocated Social Worker throughout the child/young person's admission and should ensure that both the child/young person's mental health and other assessed needs are being addressed.

The Independent Reviewing Officer or their manager is expected to attend the Pre-Discharge Meeting.

Section 5: Discharge Planning

5.1 Planning for discharge for all young people must commence on day one of admission. The CPA Discharge Planning Meeting must be held before the child/young person is discharged. The purpose of the meeting is to ensure that there is an appropriate multi-agency plan in place for the child/young person's discharge.

5.2 The CPA Discharge Planning Meeting will be arranged by a member of the Multi-disciplinary team in the inpatient Unit in conjunction with the CPA Co-ordinator. Five days' prior notice of the time/date/venue of the CPA Discharge Meeting must be given to all professionals including those not physically based on the psychiatric unit (including, if they are involved, the named/allocated Social Worker, the SW Team Manager, the Lead Health Professional and the Independent Reviewing Officer)

5.3 The meeting will be chaired by the Consultant Psychiatrist. Where the Consultant Psychiatrist does not chair the meeting, they must formally delegate authority to a member of the multi-disciplinary team in the inpatient unit.

5.4 If it is considered by the child/young person, their parents, the CPA Co-ordinator, the Clinical Team, the Social Worker/Team Manager, or the Independent Reviewing Officer that the Discharge Plans do not meet the child/young person's identified needs then this concern MUST IMMEDIATELY BE ESCALATED to Service Manager level within the inpatient provider and the Head of Service within the Children's Trust. The respective NHS Provider Trust lead for Safeguarding must be additionally notified by the young person's CPA Coordinator.

5.5 The discharge day must take into account the availability of support particularly in respect of weekends and bank holidays.

5.6 With regard to Education local authorities are required to have regard to any medical advice given by the hospital when they discharge a child, as to how much education will be appropriate for them after discharge, when they might

be ready to return to school and whether they should initially return to school on a part-time basis only.[8]

5.7 Where a child or young person is deemed unable to return to their previous education provision and they need special education provision there will need to be an assessment for an Education, Health and Care Plan (EHCP) if one is not already in place. Please note once it has been agreed to proceed with an EHCP it can take up to 20 weeks to finalise.[9] It is therefore essential that any education issues are raised at an early stage to avoid delayed discharge. See paragraph 1.2.

Children in Need and Children subject to Child Protection Plans

5.8 Discharge planning meetings must take into account the views and wishes of the child/young person and the meeting must always consider potential risk and protective factors.

5.9 The meeting should be attended by the young person, their advocate, the CPA Co-ordinator, ward staff (and the Key Worker), the Consultant Psychiatrist and the named/allocated Social Worker. Consideration should also be given to the appropriateness of inviting other key people including parents and family members (where appropriate), the child/young person's carers/future placement, the Social Worker's Team Manager and the IRO.

Children in Care

5.10 The Social Worker, Team Manager and Independent Reviewing must attend and provide reports to the meeting to ensure the most appropriate discharge arrangements and plans can be developed and agreed.

5.11 If the Independent Reviewing Officer does not attend the Discharge Planning Meeting, the named/allocated Social Worker must ensure that the IRO has a copy of the Discharge Plan, including the rationale of the Plan, the monitoring, support and treatment plans, etc. The IRO must consider all the

[8] 'Ensuring a good education for children who cannot attend school because of health needs' Statutory guidance for local authorities DfE January 2013 Paragraph 17

[9] See: https://childrens.mycareinbirmingham.org.uk/local-offer-main-page/assessment-of-needs/assessment-and-education-health-care-plan/education,-health-and-care-plans.aspx

plans that are in place, ensuring that all the child/young person's needs are to be addressed alongside the assessed mental health needs.

5.12 If the Children's Trust Team Manager is unable to attend the Discharge Planning Meeting the Head of Service must attend.

5.13 It is not considered appropriate to combine the CPA Pre-Discharge Meeting with the Statutory Child in Care Review.

5.14 The Independent Reviewing Officer is expected to review the Discharge Plans and agree the appropriateness of the Plans.

Avoiding Delayed Discharge

5.15 Continued in-patient care for a child/young person who is clinically fit for discharge is never in the child/young person's best interest.

5.16 It is the named/allocated Social Worker and their Team Manager's responsibility to have identified, in advance, an appropriate placement for the child/young person to be discharged to and arrangements made to meet any additional needs.

5.17 An Accommodation Request Form should be completed once the need for accommodation is identified and there is no need to wait for a discharge date. As long as discharge is likely within a reasonable time period e.g. three months, Children's Services Placements Team can start to approach potential providers immediately. This will allow the provider time for their own assessment and for them to start to develop a relationship with the young person and the unit.

5.18 An Interim Placement for the child/young person post discharge is to be avoided wherever possible. If this is necessary, it is very important that there are satisfactory handovers of the CPA and Care Plans to the interim placement and that there is on-going specialist support available to the

child/young person and the carers/placement throughout the interim placement.

5.19 The young person's agreement, or objection, to Care Plans should be specifically recorded along with any concerns raised.

Section 6: Discharge of the Child/Young Person

6.1 Section 117 of the Mental Health Act 1983 requires clinical commissioning groups and local social services authorities to provide aftercare services to patients who were detained in hospital for treatment under section 3, 37, 45A, 47 or 48 of the Mental Health Act and who are no longer detained.[10]

6.2 This provision of the Mental Health Act supersedes any statutory requirements under Children's legislation.

6.3 The duty to provide aftercare services exists until both the local authority and the clinical commissioning group are satisfied that the young person's mental health has improved to a point where s/he no longer requires them.

Children in Need and Children subject to Child Protection Plan

6.4 At the point of discharge, there should be a clear and coherent CPA Plan. This should include follow up arrangements, the supports available to the child/young person and carers, any specific care issues, contact arrangements and the date/time of the Child in Need review meeting.

Children in Care

6.5 At the point of discharge, there should be a clear and coherent CPA Plan. This should include follow up arrangements, the supports available to the child/young person and carers, any specific care issues, contact arrangements and the date/time of the Statutory Child in Care Review. The CPA Plan should be consistent and integrated with the child/young person's Physical Health Care Plan.

6.6 For all children the Discharge CPA Plan must be shared with all appropriate professionals – e.g. the CPA Co-ordinator, the CYPS Clinical Team, the named/allocated Social Worker, the Social Work Team Manager, the Independent Reviewing Officer, the relevant LAC Designated Nurse, the child/young person's GP

[10] See Appendix 4

N.B. Responsibility for sharing the Discharge CPA Plan lies with the CPA Coordinator.

6.7 The discharge plan should be incorporated into the child's psychiatric clinical record and shared with the community team who will provide post-discharge care.

6.8 The social worker should ensure that the discharge plan is incorporated into the child's social care record and shared with the IRO.

Discharge During Home Leave

6.9 Where a young person refuses to return to a unit from home leave and discharge is agreed, the Key Worker must immediately inform the CPA Co-ordinator and the named / allocated Social Worker. If discharge of this child/young person has to be considered in their absence, a CPA Discharge Planning Meeting should be convened as soon as possible and always within five working days. This Discharge Meeting must consider the assessment of risks involved (to the child/young person and to others), what further actions may be necessary, discharge and follow up arrangements.

Post Discharge

Children in Need

6.10 For Children in Need consideration should be given to convening a Child in Need review meeting in order to ensure the best arrangements and support are available to the young person and their family following discharge.

Children subject to Child Protection Plans

6.11 Consideration must be given to holding a core group meeting or bringing forward the Child Protection Case Conference if there is a need to amend the Child Protection plan.

Children in Care

6.12 Where a child/young person is a child in care, the child/young person's statutory review **MUST** take place within eight working days of the child/young person's discharge from the In-Patient Unit; this will be chaired by the Independent Reviewing Officer and the Social Worker/Team Manager, and CPA Co-ordinator must attend the Child Looked After review.

Section 7: Transition to Adult Services

7.1 The SCIE notes “It is easy for young people who are inpatients in hospital to become invisible, especially if their placement is stable and/or they are some distance away or out of area. Ensuring they receive good transitional planning and support is of key importance if they are to be successfully discharged from the inpatient unit.” [11]

7.2 Transition arrangements for young people vary depending on a number of factors including their level of disability, their care status, whether they were detained under the Mental Health Act and the ongoing nature of their mental health difficulties.

7.3 Hospitals and Care Homes are registered for certain age groups with inpatient mental health services generally only admitting young people from age 13 to 18.

7.4 Where a patient requires transfer to an alternate mental health service, the current inpatient service will take the lead responsibility in effecting the transfer.

7.5 In Birmingham there is a 0-25 Community Mental Health Service which avoids the need for transfer between community services at age 16 or 18.

7.6 Mental health services for young people with a moderate to severe learning disability are commissioned separately covering age 0-19.

7.7 The adult social care service is sometimes determined by the community mental health consultant who has primary responsibility for a young person’s care. If the primary need is to address a ‘functional’ mental health issue then adult social care mental health services will take over. However if a learning disability consultant is involved a young person may be transferred to adult social care learning disability services. If there is some doubt these decisions can be resolved through the Birmingham ‘Transitions Operational Group’.

7.8 Birmingham Adult Mental Health Social Care will look to make the transition to adult services as seamless as possible and where it is clear that services

[11] Mental health service transitions for young people SCIE Nov 2011
https://www.scie.org.uk/publications/guides/guide44/keymessages.asp

will be required post 18, e.g. where someone is subject to Section 117 Aftercare, then referrals can be made post 16th birthday.

Appendix 1

Notification of Admission Procedural Guidance for Children and Young People Admitted to Inpatient Psychiatric Units

When a child or young person (0-18) who is known to be a 'child in care' or subject to a 'child protection plan' is admitted to an in-patient Psychiatric unit it is imperative that the Children in Care Designated Nurse is alerted.

It is the responsibility of the staff member admitting the child to the unit to ensure the attached pro-forma is fully completed where possible to enable effective co-ordination once received.

Once completed this should be left with the Medical Secretaries who, within 1 working day of admission, will send the completed pro-forma via a secure email address (nhs.net account) to the identified secure email address:

Units to insert secure email address and telephone number for local Children in Care Designated nurse and the relevant Children in Care or Safeguarding team.

When sending the email a read receipt should be requested; this will act as confirmation that notification has been received. Confirmation of receipt will be no more than 2 working days of the initial notification being sent.

The role of the Designated Nurse does not replace the communication between staff caring for the child or young person and other agencies involved in the care plan such as the Child's Social Worker. It is a supportive measure to ensure that the health needs of the child or young person are fully reflected on admission through to discharge and in accordance with statutory guidance. The role of the Designated Nurse is to liaise with other professionals or agencies to ensure care needs are met by those responsible

Admission Information for Children in Care Admitted to Inpatient Psychiatric Units

Childs Name			
Date of Birth	/ /	NHS Number	
Placement Address or where living at time of admission			
Home or originating address if different to above			
Name and contact details of person with parental responsibility for child or main carer.			
Legal status of child (if known)			
Name and contact details of allocated Social Worker			
Responsible local authority			
Details of GP: name , address and contact number			
Responsible CCG			
School they are on roll at.			
Is there an EHCP? If so need SENAR PO contact details.			
Reason for and date of admission inclusive of route (voluntary/detained)			
Date of Admission	/ /	Last Assessment?	/ /
Ward/Keyworker			

Appendix 2

Flow Chart of Care Pathway for Children in Care Admitted to An inpatient Psychiatric Unit

Admission

- Admission
- Keyworker notifies Named/Allocated Social Worker and Children in Care Designated Nurse within 1 working day of admission. Where identity of SW is not known, relevent Social Care Team is contacted

3 working days

- Named/Allocated Social Worker confirms legal status of Young Person and details about birth parents / contacts and any other relevent information necessary to manage risk within 3 working days of admission. SW informs IRO and relevent Social Care Director and updates on weekly basis
- Named/Allocated Social Worker immediately commences work to identify what further support may be required by placement to ensure young person is able to return to placement at earliest opportunity or where placement has irretrievably broken down to identify an alternative placement
- Children in Care Designated Nurse, confirms identity of Lead Health Professional and any significant health information to enable management of risk within 3 working days. Lead Health professional liases with inpatient unit regarding physical health checks

10 working days

- Initial Formulation Meeting held within 10 working days - convened by member of Unit Multi-disciplinary team - often the young person's keyworker in collaboration with their CPA Coordinator
- Named/Allocated SW and Lead health Professional must attend.
- CPA Coordinator and Clinicians from In-patient Unit attend

4 weeks post admission

- First CPA Review - convened by CPA Coordinator
- Named/Allocated SW and Lead health Professional must attend.
- CPA Coordinator and Clinicians from In-patient Unit attend
- YP advocate invited

6 weekly

- CPA reviews - convened by by member of Unit Multi-disciplinary team - often the young person's keyworker in collaboration with their CPA Coordinator
- Named/Allocated SW and Lead health Professional must attend.
- CPA Coordinator and Clinicians from In-patient Unit attend
- YP advocate invited

Discharge Planning Meeting

- Timing according to clinical need. IRO may attend in observational capacity but is clearly expected to agreed discharge plan
- Discharge plan must be communicated in writing to all relevent professionals - by CPA Coordinator

Discharge

- Clear coherent CPA Plan in place detailing follow-up arrangements, supports available to yp and their carers, any specific care issues, contact arrangements and date/time of Statutory LAC Review/core group or CPC. CPA Plan should be consistent with yp's physical health care plan.

Post-discharge Follow-up

- CLA review must occur within 8 working days of discharge, chaired by the IRO. The YP's CPA Coordinator, Named/allocated SW and their team manager, the Lead health professional and the YP's keyworker from the respective unit must attend.

Appendix 3

Glossary of Terms

This glossary is intended for use only as a brief summary of terms referred to within the document.

Assessment On Admission *--- This is conducted by a nursing staff member and a Psychiatrist (which can be an on call duty Psychiatrist). Nursing team completes a mini-social history and provisional risk assessment on arrival and a Psychiatrist then does a medical evaluation as soon as possible but most likely within 24 hours.* ***NB: Discharge planning occurs from the moment the young person is admitted onto the unit.***

Cafcass - Children and Family Court Advisory and Support Service *– is a Social work service independent of the courts, social services, education and health authorities and all similar agencies. Cafcass operates within the law set by Parliament and under the rules and directions of the family courts. Its role is to:*

- *safeguard and promote the welfare of children*
- *give advice to the family courts*
- *make provision for children to be represented*
- *provide information, advice and support to children and their families*

Care Programme Approach (CPA) Meetings*—These are conducted 4 weeks after the formulation meeting and 6 weeks there-after for as long as the young person remains on the unit. The meeting is attended by representatives from all members of the MDT team. The client's progress in all areas is discussed and reviewed and recommendations are made by all parties involved regarding the young person's care. External professionals are invited to attend including education professionals, CAMHS professionals, external psychiatrists, the General Practitioner, the Youth Offending Team, any pertinent community partners, and CAMHS crisis outreach team if they have an on-going role. Most importantly, the young person and their parents/caretakers attend. The young person sees an advocate and goes over their CPA documents prior to the meeting and their views are solicited, including making sure that they agree on the contents of the CPA document. Discharge plans are always being considered during this meeting to insure that we are working towards mainstreaming the young person back out into the community as soon as possible. Social care is invited to attend all meetings if the child is receiving support from a social worker.*

Care Order (preceded by Interim Care Order [S38]) Section 31, Children Act (1989)
The child is Looked After by the local authority by the order of a court. Parental responsibility is shared between the birth parent and the local authority.

Children Act 1989
This is the primary legislation that sets out the statutory duties and responsibilities in order to safeguard and promote the wellbeing of children. It defines a child as any person who has not attained their 18th birthday.
Section 85 of the Children Act 1989 requires Health or Education Authorities to notify Children's Services Specialist Services where they either have accommodated a child for more than three months, or at the time they first accommodate the child, intend to do so for more than three months.
Section 86 of the Children Act requires anyone providing accommodation for a child in a residential care home or nursing home for more than three months, or intend at the outset to accommodate them for more than three months, to similarly notify Children's Services.

Child Protection Case Conference (CPCC) *A Child Protection Case conference will hear information about the family and about concerns that have been expressed, discuss whether or not the child is at risk of significant harm and whether there should be a 'child protection plan'. If it is decided that there is a need for a child protection plan, the child's name will be placed on the child protection register - also called the "at risk" register.*

Child Protection Plan (CPP) *A child protection plan:*

- *Assesses the likelihood of the child suffering harm and look at ways that the child can be protected*
- *Decides upon short and long term aims to reduce the likelihood of harm to the child and to protect the child's welfare*
- *Clarifies people's responsibilities and actions to be taken*
- *Outlines ways of monitoring and evaluating progress.*

CIN / Child in Need Assessment - *A Child in Need is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services; or a child who is disabled. In these cases, assessments by a social worker are carried out under section 17 of the Children Act 1989.*

Core Group - *The core group is responsible for formulation and implementation of the detailed child protection plan, previously outlined at the child protection conference. Core group membership will have been identified at the child protection conference and includes the lead social worker, parents / carers, child (if appropriate) and other relevant family members.*

Discharge Planning Meeting (Conducted as a CPA)--- O*nce the provisional discharge date is confirmed, discharge is more actively discussed during this meeting and plans are made to identify a date to discharge the young person back out into the community. This Meeting is attended by everyone involved in the child's life, by the young person and their parents/caretakers. CAMHS Crisis team attends if they have a role to play in supporting the young person's discharge by providing short term community support. The timing happens according to the clinical need of the young person. The social worker is also invited to attend if the child is overseen by Social Care.*

Discharge CPA*--- This meeting is conducted most likely the day the young person is planned to discharge from the Unit. All internal professionals are represented and all external professionals necessary for the child to be discharged successfully are invited to attend, including Education, CAMHS, CAMHS Crisis Outreach team, the GP, lead health professional, the external Psychiatrist, the early intervention and eating disorders teams (if clinically indicated), and representatives from social care. At this meeting, plans for discharge are finalized including the frequency and type of community support provided, plans for the young person's educational provision, and plans for the crisis team to provide 6-8 weeks of community support. Plans for follow up care with CAMHS, the GP and the external Psychiatrist are put in motion and if the child is on medication, they are given prescriptions to last them until they can be seen by their community CAMHS Psychiatrist and/or General Practitioner. Any medical issues are discussed which may need to be followed up on by the GP.*

Designated Doctor and Nurse *– strategic role to assist health bodies and social care in fulfilling their responsibilities as corporate parent for the child or young person. Provides expert advice and support to all health service providers (including child and adolescent mental health services, primary and secondary care providers), local authorities and any health body providing care for a child who is Looked After or subject to a child protection plan.*

Duty to Investigate, Section 47, Children Act (1989)
The local authority has a statutory duty to make enquiries when it has reasonable cause that a child is suffering or likely to suffer significant harm. Section 47 therefore empowers local authorities to call upon other professionals and agencies to assist them. When carrying out s47 enquiries the local authority has a statutory duty to obtain access to the child and therefore this duty is not subject to permission by those with parental responsibility.

Emergency Protection Order (EPO) Section 44, Children Act (1989)
This order lasts for a maximum of eight days and can be extended by up to seven days. The local authority can apply to the court when there is a belief the child is suffering or likely to suffer significant harm if the child is not removed from where they are or kept in a particular place (e.g. hospital).Whoever is granted the EPO (e.g. Social care) acquires temporary parental responsibility. In an emergency, immediate protection can be obtained by the police.

EHCP – *Education Health & Care Plan*

Formulation Meeting*--- This meeting is held within two weeks of admission or as soon as can be scheduled. This meeting is led by a member of the MDT team and it brings together various, more thorough assessments and recommendations that have been done during the previous two weeks (i.e.: Educational assessment, Psychological assessment, Psychiatric assessment, Social Work assessment, Family Therapy assessment, Occupational Therapy assessment, Psychoanalyst assessment, and nursing assessment.) All formulations are considered and combined into a package of care which is then offered within the unit, including deciding upon the permanent care pathway that the young person will be on for the duration of their treatment. Most importantly, the young person and their family/ carers are a part of this meeting. The meeting can end up becoming the discharge CPA meeting if it appears that the young person is ready to be discharged and the parents agree with the recommendation for discharge.*

GP – *Lead Primary Care professional who holds the main health record for a patient.*

Independent Reviewing Officer (IRO) – *The appointment of an independent reviewing officer (IRO) is a legal requirement under Section 118 of the Adoption and Children Act 2002. They are social work professionals employed or engaged by the local authority. They are distinct from the allocated Social Worker and have a statutory responsibility to quality assure and oversee care planning for children in care and ensuring that the child's views and wishes are being paid due regard. This includes chairing the statutory reviews for children in care and ensuring that the Care Plan is effective in meeting the needs of the child and safeguarding and promoting the child's welfare. The IRO must be kept informed of any significant changes to the Care Plan and significant incidents and events affecting the child, including placement moves. If the IRO is concerned about any aspect of the Care Plan or its implementation they have a duty to raise those concerns with the responsible Social Worker and Manager and escalate those concerns to Senior Managers and ultimately to Cafcass (see below) if those concerns are not addressed.*

Lead health professional *– The key community child health professional for a child, usually the school nurse or health visitor. For a looked after child this includes undertaking health assessments, co-ordinating and monitoring health care plans and acting as key health contact for social workers and carers.*

Legal Aid, Sentencing and Punishment of Offenders Act, 2012
This is new legislation that became effective on April 1st 2013. It requires that any child who is accused of committing a criminal offence and placed on remand in a Young Offenders Institute or secure accommodation will be classed as a Looked After Child under section 20, Children Act, (1989) and benefit from the same support and services as any other child in care. This does not include the

requirement for statutory health assessments to be undertaken if the child was not looked after prior to being remanded.

Mental Health Act 1983: *Section 2 of the Mental Health Act 1983 allows for a patient (child or adult) to have their mental health needs compulsorily assessed as an in-patient for up to 28 days. Section 3 provides for the person to compulsorily receive treatment as an in-patient for up to six months. S.3 can be renewed for a further period of 6 months and then renewed for periods of one year therefore. Section 4 of the Mental Health Act 1983 is an emergency order that lasts up to 72 hours. It is implemented by just one doctor and an Approved Mental Health Practitioner, in an emergency in which there is not time to summon a second suitable doctor in order to implement a Section 2 assessment order or Section 3 treatment order. Once in hospital, a further medical recommendation from a second doctor would convert the order from a Section 4 emergency order to a Section 2 assessment order. Section 4 emergency orders are not commonly used.*

Any Child in Care admitted voluntarily or under either section of the Act should have their care plan reviewed by an Independent Reviewing Officer. If the child is in care under S20 CA89 and admitted under section 3 MHA83 their status as a Child in Care ends and they become a child in Need (s17 CA89). Children who are subject to care orders (i.e. s31 CA89) remain Children in Care regardless of whether they are admitted voluntarily or compulsorily.

MDT (Multi-disciplinary Team) *- refers to all professionals on the unit (i.e.: Nursing, Psychology, Psychiatry, Social Work, Education, Occupational Therapist, Family Therapist, and Psychoanalyst).*

MDT Assessment*--- This is conducted after admission within 3 working days by two clinical members of the MDT team and most likely a member of the crisis team, particularly if the crisis team member has been working with the young person. A Psychiatrist may or may not be present for an MDT assessment. If the Psychiatrist is not present, s/he is consulted with on pertinent issues related to the client's mental status, risk assessment, medical issues, etc. An education staff person is generally present, as well. During this assessment, a more thorough social history, risk assessment, educational assessment, safeguarding assessment and developmental assessment is conducted. External professionals are invited to observe or actively participate during the assessment and to provide recommendations. A provisional care pathway is also discussed and decided upon.*

Named Nurse (Safeguarding or Children in Care) *– Specialist nurse within children's community services who provides specialist advice, guidance and supervision to staff working within community services on child safeguarding. Children in Care Specialist Nurses lead community health services children placed in that area and for those whose health care is hosted by another provider. They co-ordinate service delivery and liaise between social care teams and other provider organisations to ensure delivery of care within universal services.*

Nearest Relative *- A Nearest Relative is a relative of a mentally disordered person. There is a strict hierarchy of types of relationship that needs to be followed in order to determine a particular person's Nearest Relative: husband, wife, or civil partner; son or daughter; father or mother; brother or sister; grandparent; grandchild; uncle or aunt; nephew or niece; lastly, an unrelated person who resides with the mentally disordered person. Thus a person's Nearest Relative under the Act is not necessarily their "next of kin".*
A mentally disordered person is not usually able to choose their Nearest Relative but under some circumstances they can apply to a County Court to have a Nearest Relative replaced. In practice, such applications are more commonly made by Social Services Departments. The Nearest Relative has the power to discharge the mentally disordered person from some sections of the Act.

Placement Order, Adoption & Children Act, (2002) – *The long term plan for the child is adoption. Parental responsibility is shared between the local authority and the birth parents when the child is with foster carers. Prospective adoptive parents may consent to most healthcare interventions. Prospective adoptive parents would be considered a 'significant other' if an application was made for detention to hospital – Local Authority would identified as the Nearest Relative under s.27 of the MHA for the purposes of the AMHP fulfilling their duty to 'inform' (s.2) or 'consult' (s.3) the NR.*

Police Protection Section 46, Children Act (1989) - *A police officer can remove a child/or prevent the removal of a child (e.g. from hospital) for up to 72 hours if they believe the child is suffering or likely to suffer significant harm if action were not taken. This enables time, if appropriate, for an EPO to be obtained. This is only used in exceptional circumstances.*

Pre-admission Assessment*— This is conducted by two members of the MDT team, along with a member of the crisis team, to determine if inpatient admission is warranted or if young person can be maintained in the community with additional community and crisis outreach team support. If no admission is deemed appropriate, a community care plan is discussed amongst professionals and decided upon to be undertaken by the CPA Coordinator in conjunction with relevant professionals who have been working with the young person. If an inpatient admission is decided upon, the below stated assessments take place. A comprehensive CPA assessment should have been done in the community prior to this assessment being undertaken to underpin the relevant concerns to be more fully assessed for the purpose of deciding on whether or not an inpatient admission is warranted.*

Remanded to local authority care Section 21, Children Act, (1989)
Children who are on remand whilst criminal investigations take place may be placed in local authority care instead of being placed in a Young Offenders Institution.

Responsible Clinician – *Responsible clinician" is defined in s34 (MHA, 2007) as:*

(a) in relation to a patient liable to be detained by virtue of an application for admission for assessment or an application for admission for treatment, or a community patient, the approved clinician with overall responsibility for the patient's case;

(b) In relation to a patient subject to guardianship, the approved clinician authorised by the responsible local social services authority to act (either generally or in any particular case or for any particular purpose) as the responsible clinician

"Approved clinician" is defined in s145 as:
... a person approved by the Secretary of State (in relation to England) or by the Welsh Ministers (in relation to Wales) to act as an approved clinician for the purposes of this Act

In contrast with a Responsible Medical Officer, an RC does not need to be a doctor. However, sometimes a doctor is still required, for example the recommendations for initial detention under section 2 or 3 must be made by a registered medical practitioner.

Section 20, Children Act (1989) - *Child is in the care of the local authority with the parent's consent, or with the young person's own consent if aged 16 or 17 years. Birth parent retains parental responsibility.*

Secure Order Section 25, Children Act, (1989)- *The child is placed in secure accommodation for their own safety or the safety of others.*

SENAR PO – *Special Educational Needs Assessment & Review Principle Officer.*

Statutory Child in Care Review - *A regular meeting that brings together the people most closely concerned with the care of a child in care. The first review must be held four weeks* after the child becomes accommodated; there must *be a second review no more than three months after that; further reviews must be held at least every six months.*

Weekly Ward Reviews--- *Members of the nursing, education and MDT team come together with the Psychiatrist to discuss the client's weekly progress on the ward and to discuss alterations to the client's care on the ward. The young person's views are solicited in written and verbal formats, and decisions are made about home leave, family visits, observation levels, whether or not to alter the care plan, etc. This meeting is only for internal staff.*

Appendix 4

Section 117 Aftercare

Birmingham Children's Services Procedure Manual

Chapter 4.3.2 Aftercare under Section 117 of the Mental Health Act 1983 (Copied 06/02/2017)

SCOPE OF THIS CHAPTER

This procedure applies when a child or care leaver is discharged from hospital after having been detained under the Mental Health Act 1983.

Contents

1. The Duty to Provide Aftercare Services

Section 117 of the Mental Health Act 1983 requires clinical commissioning groups and local social services authorities to provide aftercare services to patients who were detained in hospital for treatment under section 3, 37, 45A, 47 or 48 of the Mental Health Act and who are no longer detained. Services under this section must be provided in co-operation with relevant voluntary agencies.

The sections of the Act to which this duty relates are all concerned with compulsory detention in a hospital:

- Section 3 deals with patients who are detained in hospital for treatment;
- Section 37 gives the magistrates' court or crown court a power to direct that a person will be detained in hospital either following conviction for an offence or on being satisfied that the person carried out the action that would have constituted the offence;
- Section 45A gives the higher courts a power to direct that a person convicted of an offence shall be detained in hospital instead of being detained on prison;
- Section 47 authorises the Secretary of State to direct that a person serving a prison sentence shall be detained in hospital;
- Section 48 authorises the Secretary of State to direct that a person who has been remanded to custody or detained under immigration legislation shall be detained in hospital.

The duty to provide aftercare services remains in force until the health authority and the local authority are satisfied that the person concerned is no longer in need of such services.

Aftercare services provided under section 117 can include services provided directly by the local authority or by the NHS or services they commission from other providers. Services should aim to support the person in regaining or enhancing their skills, or learning new skills, in order to cope with life outside hospital.

Although the duty to provide aftercare services begins when the young person leaves hospital, planning should start as soon as possible after s/he is admitted. The worker should discuss with health professionals how and when the young person's needs for aftercare will be assessed and the arrangements for identifying appropriate services to address these needs.

Aftercare planning will involve a number of medical, nursing and other practitioners; the issues that should be considered in the assessment of need are listed below. A single assessment under the guidance in *Working Together to Safeguard Children* could be used for this provided that particular attention is given to these issues.

It is important that those who are involved in discussions about aftercare plans are able to make commitments about their own continuing involvement and the services to be provided or commissioned by the City Council. If the worker will need to seek approval for this, extra time must be set aside for planning so that this does not delay the date for the young person's discharge from hospital.

Practitioners should be aware that the plans to provide aftercare services will be a significant factor in deciding when the young person will be discharged from hospital. It is important to ensure that assessments are up to date and commitments in principle to provide services have been made in advance of any hearing.

The practitioners concerned, in discussion with the young person, should agree an outline of the young person's needs and a timescale for implementing the various aspects of the aftercare plan. The plan should clearly allocate responsibility and deadlines for completing each task.

The aftercare plan must be recorded in writing. It will be reviewed regularly until it is agreed that it is no longer necessary. It is essential that any changes are discussed with the young person, his/her parents and others likely to be affected before they are implemented.

The duty to provide aftercare services exists until **both** the local authority and the clinical commissioning group are satisfied that the young person's mental health has improved to a point where s/he no longer requires them. Services must not be withdrawn solely because the young person has been discharged from the care of specialist mental health services, or because an arbitrary time limit has passed.

2. Issues to be Considered in Aftercare Planning

A thorough assessment is likely to involve consideration of:

- Continuing mental healthcare;
- The psychological needs of the young person and of their family;
- Physical healthcare;
- Daytime activities or employment;
- Appropriate accommodation - if the aftercare plan includes the provision of accommodation, and the young person has committed one or more criminal offences, the circumstances of any victims of the offence(s) and of their families should be taken into account when deciding where the young person should live;
- Identified risks and safety issues;

- Any specific needs arising from, for example, co-existing physical disability, sensory impairment, learning disability or autistic spectrum disorder;
- Any specific needs arising from drug, alcohol or substance misuse;
- Any parenting or caring needs;
- Social, cultural or spiritual needs;
- Counselling and personal support;
- Assistance in welfare rights and managing finances;
- The involvement of authorities and agencies in a different area, if the young person is not going to live locally;
- The involvement of other agencies, for example the probation provider or voluntary organisations;
- Any conditions likely to be imposed by the Secretary of State for Justice or the Tribunal;
- Contingency plans (should the young person's mental health deteriorate); and
- Crisis contact details.

End