North Yorkshire and York Safeguarding Children Partnership

Multi Agency Protocol for Children and Young People Admitted to an Acute Hospital Trust with Self Harm and/ or Suicidal Ideation where there is need for a multi-agency discharge plan

North Yorkshire and City of York Safeguarding Children Partnership

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Title	**Multi Agency Protocol for Children and Young People Admitted to an Acute Hospital Trust with Self Harm and/ or Suicidal Ideation where there is need for a multi-agency discharge plan**
Version	**1.0**
Date	**13/12/22**
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Update and Approval Process			
Version	**Group/Person**	**Date**	**Comments**
1.0	CYSCP Safeguarding and Professional Practice (SAPP) Sub-Group	13/12/22	Baseline version for approval
2.0	CYSCP Safeguarding and Professional Practice (SAPP) Sub-Group	25/01/23	Updated following feedback

Issue Date	**January 2023**
Review Date	**January 2023**
Reviewing Officer	**CYSCP and NYSCP Business Unit**

1. Introduction

The purpose of this guidance is to support multi-agency practitioners to make appropriate arrangements which support the safe and timely discharge from an acute hospital for children and young people who self-harm and / or have suicidal ideation.

The protocol is intended to ensure that all practitioners are clear about the steps to take to ensure that no child is discharged from an acute hospital into an unsafe environment, where their health or well-being may be compromised or where further significant harm could occur. The protocol also aims to ensure there are no unnecessary delays in discharging a child who is otherwise medically fit

1.1 Principles

1. Any child or young person who self-harms or expresses thoughts of self-harm or suicide, must be taken seriously. Appropriate help and intervention should be offered at the earliest opportunity. There is a North Yorkshire and York Multi Agency practice guidance to support practitioners in their response to children who self harm or have suicidal ideation. Please note the York practice guidance is currently being produced and the link will be added once it is completed.

   https://www.safeguardingchildren.co.uk/parents-carers/parents-and-carers-self-harm-and-suicide-ideation/

2. 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.

3. Children should not remain in an acute hospital once they are medically fit for discharge. 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.

2.0 The Discharge Planning Meeting (DPM)

Not all admissions of children and young people who self-harm or have suicidal ideation require a DPM. However, a DPM must be convened whenever there are complexities that require a multi-agency coordinated approach to safely address their needs and discharge from an acute hospital. Complexities are far ranging and difficult

to quantify. However, this protocol is relevant when a child or young person is physically fit for discharge but remaining mental health concerns require a multi-agency approach to allow safe discharge from an acute setting. In all cases of such complexity a referral to Children's Social Care or Early Help services should be considered in line with multiagency threshold guidance.

https://www.safeguardingchildren.co.uk/Resources/threshold-guidance/

https://www.saferchildrenyork.org.uk/Downloads/MASH%20Threshold%20document.pdf

Consent from the parent/carer or adult with parental responsibility must be obtained, in line with the threshold guidance. In circumstances where obtaining consent could place the child or young person at further risk of harm or if consent cannot be obtained from parent/carer or adult with parental responsibility, safeguarding advise should be sought from organizational safeguarding leads.

2.1 Agency attendance at the DPM

Attendance at DPM will vary depending on the reasons for admission and needs of the young person. At a minimum, it should involve Children's Social Care (if involved), Lead Clinician or their delegate, a member of nursing staff, and a CAMHS Practitioner. If it is deemed necessary, that information is required from North Yorkshire Police to inform the case, this will be obtained by Children's Social Care and attendance discussed/ agreed if needed. Consideration should be given to involving the Safeguarding Children Team for the Hospital Trust. However, if they are not required to attend or cannot attend, they must be informed of the planning meeting and its outcome.

Consideration should be given to liaising with other single or multi-agency planning processes, e.g., Care, Education and Treatment Reviews and Education and Health Care Plans.

The young person and their parent/carers should be invited to the meeting. If they cannot attend, their views should be sought and shared at the meeting. If the young person and or their parents/carers do not attend the meeting, it must be agreed within the meeting who will feedback the outcome to them.

2.2 Convening the Discharge Planning Meeting

The responsibility for beginning the DPM process will be the Lead Clinician from the Acute Trust caring for the child or young person, with support from the Mental Health Trust and Children's Social Care/ Early Help Services if involved. The chairing, minuting, and circulating of the discharge plan for the DPM will be agreed at the meeting. The DPM should take place in a timely manner and/ or within 24 hours prior to discharge. If the child or young person is currently being cared for within the

Emergency Department and there are complexities, as described

above, which would require the convening of a DPM, the child or young person should be admitted to the Trust. Key to ensuring an effective discharge process is timeliness of response, collaborative working and information sharing.

2.3 Agenda for the DPM

The DPM will address:

2.3.1 Background and reasons for admission
2.3.2 Voice of child and their lived experience
2.3.3 Voice of family and experiences. Wishes for future planning of assessments and plan of care whilst in hospital
2.3.4 Develop the discharge plan and plan for follow up care in the community

2.4 The Discharge Plan

The discharge plan should be documented on the agreed template (see Appendix 1). An agreed multi-agency discharge plan will set out arrangements for the care and safety of the child whilst in hospital and following discharge 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. The plan will specify as informed by the wishes and feelings of the child and family:

2.4.1 The identified risks, triggers and warning signs

2.4.2 Protective factors

2.4.3 Treatment and support plan with timescales: Consider safety of the discharge plan if child or young person is to be discharged over the weekend and/ or Bank Holiday

2.4.4 Details of follow up appointments

2.4.5 Status and ownership of the plan / Interface with other plans

2.4.6 Details of lead professional(s)

2.4.7 Contingency plan and a crisis/ contingency plan including informing North Yorkshire Police and/ or Yorkshire Ambulance Services of any risks as appropriate

2.4.8 Follow up meetings and who will attend these. Note these may need to include other agencies that will be working with the child/young person such as their school or college; youth worker; 0-19 Healthy Child Practitioner or GP

2.4.9 Safety planning and involvement from Children's Social Care upon discharge – when are visits being completed, how often and how are the network being

encouraged and involved in the support plans for the child. How often will this be reviewed and how will be work in partnership with other agencies and ensure a collaborative approach with the young person, their family and the professionals around them. 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. A copy should be given to the Parents/ Carers and child /young person. The Safeguarding Children Team for the involved Trust must be informed of the outcome of the meeting.

3.0 Escalation/Conflict Resolution

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

3.1.1 Raise initial problems with a team manager/clinical lead/ or on call Manager out of Hours.

3.1.2 Raise with their organisations safeguarding children team and agree steps to resolve.

3.1.3 If it cannot be resolved, then the manager/clinical lead will follow the Local Safeguarding Children Partnership Professional Resolution Guidance supported by the safeguarding team from the organisation.

https://www.safeguardingchildren.co.uk/?s=professional+resolution

https://www.saferchildrenyork.org.uk/cyscp-practice-guidance.htm

In cases where the young person has been assessed as requiring admission to a specialist CAMHS inpatient bed and the bed is not immediately available see Appendix 2.

Appendix 1 Discharge Planning Meeting Template

My Discharge Plan	
Child/Young Person's Full Name	**Details of Parents/Carers and who have Parental Responsibility**
Date of Birth	**NHS number**
Background and reason for my admission: **Details of any previous admissions for similar reasons:**	
Date of the today's discharge meeting **Dates of any previous meetings since admission/outcome**	
Names of those attending	**Job Role**
Outcome of Assessment(s) Hospital CAMHS CSC Other	
My and my families thoughts and feelings about our life currently	

My and my families wishes for the future
My identified Risks, Triggers and Warning Signs
What can we do to help keep me safe / when do I feel safe?
Who will be there to help me if things start to go wrong and who can I talk to if I feel I am not being supported *(consider social worker, safety plan, networks and agencies who might be involved)*
My Support Plan: (to include medication, any additional medical or social investigations required, direct work with young person and other family members, safety measures)

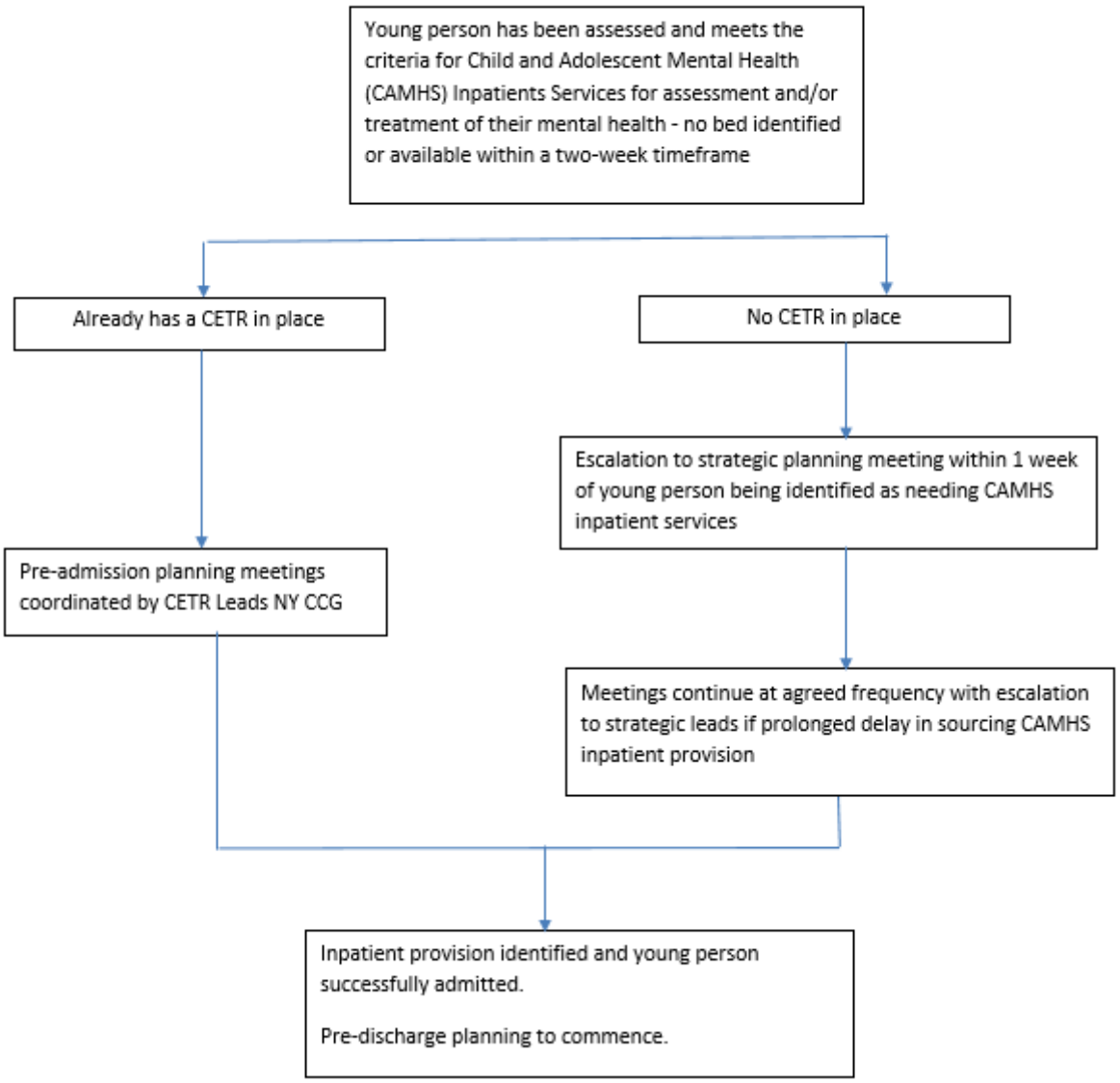
What do I want to be achieved	**What will be provided**	**Who is responsible**	**Timescales**

Are any specific arrangements required for weekend and holiday periods?
My follow up appointments visits and future contacts (timeframe and by whom)

My Lead Professional(s)/ key contacts		
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**

Appendix 2

Escalation Pathway – Access to CAMHS Inpatient Unit Strategic Planning Meeting


Young person has been assessed and meets the criteria for Child and Adolescent Mental Health (CAMHS) Inpatients Services for assessment and/or treatment of their mental health - no bed identified or available within a two-week timeframe
Already has a CETR in place
No CETR in place
Escalation to strategic planning meeting within 1 week of young person being identified as needing CAMHS inpatient services
Pre-admission planning meetings coordinated by CETR Leads NY CCG
Meetings continue at agreed frequency with escalation to strategic leads if prolonged delay in sourcing CAMHS inpatient provision
Inpatient provision identified and young person successfully admitted.
Pre-discharge planning to commence.

Strategic Planning Meeting

It should be noted that this strategic meeting should not replace or duplicate any operational care planning meeting, but information should be shared between the two meetings.

Escalation to strategic planning meeting: Social Work Management Team along with relevant group manager and/or CAMHS team identify situation where young person requires inpatient CAMHS service, but this is not available within a two-week timeframe. Discussions to take place with Heads of Service in relevant agency and meeting convened.

Convening meeting: meeting can be convened by any senior manager who identifies that a specialist CAMHS inpatient service is required for a young person in need of clinical assessment and care and that bed is not available.

Membership of meeting:

- Head of Service COY Children's Social Care
- Senior manager CAMHS
- Children's Commissioning Lead Humber and North Yorkshire Health and Care Partnership (York)
- NHS E/Provider Collaborative Senior Commissioning Lead for CAMHS
- Designated Nurses for Safeguarding/ Children in Care if appropriate
- Safeguarding Children Team from relevant mental health provider
- Consultant Psychiatrist for young person
- Any other appropriate senior professional involved with the young person

- **Chairing:** Senior colleague from NHS E/Provider Collaborative Senior Commissioning Lead for CAMHS or TEWV CAMHS (to be agreed at the first meeting)

Minuting: notes should be recorded for all meetings and an action log maintained. Responsibility for taking notes and maintaining action log to be agreed at initial meeting. (Consideration should be given to recording meetings taking place virtually to support accurate minuting).

Frequency of meeting: frequency of meetings to be agreed with attendees and will be dependent on levels of risk and availability of CAMHS inpatient services.

Objectives of meeting:

- Consideration should be given to whether or not the young person has a diagnosis of LD or autism and whether the young person is on the Dynamic Risk Register and if so, whether referral to the CETR process should be made
- To determine a shared understanding of risk levels and levels of need, and how this is going to be managed
- To agree care and support needs for the young person whilst awaiting availability of CAMHS inpatient provision
- To explore collaboratively how those care and support needs may best be met, including alternative/additional bespoke commissioning arrangements and funding for same
- Working together to explore all avenues for appropriate placement for young person
- Ensuring that any necessary assessments and documentation are completed and available prior to planned admission (e.g. assessments under the Mental Health Act)

Communication:

- The young person and their family should be kept informed of any decisions agreed at the strategic planning meeting.

- The outcome of strategic planning meetings should be fed back to the chairperson of any operational meetings taking place around the day-to-day care and support for the young person.
- There should be ongoing communication between the strategic planning meeting and the CAMHS inpatient unit (once identified) to support the admission process.

Stepping down: Once a placement is identified, the strategic planning group will cease to meet, and planning will be handed over to the operational group and care coordinators.