Children and Young People Mental Health and Safeguarding Discharge & Safety Planning Multi-Agency Protocol: Princess Royal University Hospital (PRUH)

May 2023

Contents

1. Partners to the Protocol 3
2. Purpose and Scope 3
3. Principles 4
4. Linked Policies and Procedures 4
5. Roles and responsibilities of the parties to this protocol 5
6. Children's Social Care 6/7
7. Role of the ED/Paed's Staff & Safeguarding Children Team (SCT) 7/8
8. Children admitted to Hospital with presenting mental health or complex needs 8/9
9. The following processes will be followed 9/10
10. The allocated social worker will 10
11. Child and Adolescent Mental Health Services Practitioners (Oxleas CAMHS) 10/11
12. The Discharge Planning Process 12
13. Agency attendances at the DPM 12
14. Convening/Chairing the Discharge Planning meeting 12/13
15. Agenda for the DPM 13
16. The DPM will address 13
17. The discharge plan will specify 13/14
18. Escalation/Conflict Resolutions 14
19. References 14
20. Child Protection Section 47 Enquiries and Strategy Meetings 14

Glossary 16

Appendix 1 Discharge Planning Meeting Template 17

Appendix 2 – NHS England - Mental Health: Escalation when an individual is waiting for an inpatient admission 20

Appendix 3 – Escalation Process: Key Contacts 21

- Oxleas CAMHS - Escalation Process 21
- LBB Children's Social Care Escalation Process 22
- PRUH: Children and Young People Escalation Process 23

1. Partners to the Protocol

Kings College London NHS Trust (Princess Royal University Hospital)

Borough of Bromley (Child Social Services)

Oxleas NHS Foundation Trust (CAMHS Crisis Pathway)

South East London ICB (Bromley)

2. Purpose and Scope

2.1 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.

2.2 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.

2.3 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 include 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.
- ✓ Children subjected to Trafficking/FGM/ Modern Slavery
- ✓ 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.

3. Principles

3.1 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.

3.2 Most children who have been admitted with mental health needs will need ongoing 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.

3.3 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.

3.4 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 Bromley Children's Social Care.

3.5 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 Bromley Children's Social Care must be made to the Bromley Children and Families Hub who will determine the level of response.

4. Linked Policies and Procedures

4.1 The protocol should be read in conjunction with:

- ✓ The London Safeguarding Children Procedures
- ✓ PRUH Safeguarding Guideline for Paediatricians Algorithm for Safeguarding
- ✓ PRUH Safeguarding Children & Young People Policy
- ✓ OXLEAS NHS Foundation Trust Child Protection Policy

5. Roles and responsibilities of the parties to this protocol

5.1 The protocol applies to all departments and wards where children and young people are being treated and to all teams in Bromley, and Acute Hospital Practitioners.

5.2 Assessment of the child or young person should include a full assessment of the family, their social situation, and any safeguarding issues.

5.3 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.

5.4 Children under the age of 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”.

5.5 Follow the Hospital Safeguarding Children Procedures and where necessary make appropriate referrals to Children’s Social Care (CSC). 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.

5.6 The referral to Children’s Social Care (CSC) should include information about the background history and family circumstances, the community context, and the specific concerns about the current circumstances, if available.

5.7 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). Any child seen by a psychiatrist or MH worker such as CAMHS should be subject to a written risk assessment that is shared at the discharge planning meeting to determine best plans for the child.

5.8 The admitted patient is the responsibility of the medical team and the responsibility for discharge lies jointly between the responsible Medical Consultant and CAMHS Practitioner.

5.9 Permission for discharge should only be provided once the Consultant/Paed’s Practitioner 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. This will be influenced by the written risk assessment.

5.10 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.

5.11 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.

5.12 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.

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

6. Children Social Care

6.1 The Children Acts of 1989 and 2004 set out specific duties for local authorities. Section 17 of the Children Act 1989 puts a duty on the local authority to provide services to children in need in their area, regardless of where they are found; section 47 of the same Act requires local authorities to undertake enquiries if they believe a child has suffered or is likely to suffer significant harm.

6.2 These duties placed on the local authority can only be discharged with the full cooperation of other partners, many of whom have individual duties when carrying out their functions under section 11 of the Children Act 2004. Under section 10 of the same Act, the local authority is under a duty to make arrangements to promote cooperation between itself and organisations and agencies to improve the wellbeing of local children. This co-operation should exist and be effective at all levels of an organisation, from strategic level through to operational delivery.

6.3 The Children Act 2004, as amended by the Children and Social Work Act 2017, strengthens this already important relationship by placing new duties on key agencies in a local area. Specifically, the police, clinical commissioning groups and the local authority are under a duty to make arrangements to work together, and with other partners locally, to safeguard and promote the welfare of all children in their area.

6.4 Everyone who comes into contact with children and families has a role to play.

7. Role of the Emergency Department/Paed's Staff & Safeguarding Children Team (SCT)

7.1 Frontline Emergency Staff to complete Childrens Social Care referral via EPR

7.2 Frontline staff to inform SCT of new admission on day of admission and if admitted over the weekend to be informed by 10:00am on Monday. Referral to the SCT should be made with the CYP presenting with any of the following:

- ✓ Emotional and mental health distress, requiring a referral to CAMHS.
- ✓ On Enhanced observation and requiring an RNMH
- ✓ A history of being known to CAMHS, CSC and no suitable place of discharge clearly identified.
- ✓ Complex discharge anticipated – e.g., difficult to manage behaviour, requiring more than one RMN, police custody, S136, CLA and parents wishing for CYP to stay in the hospital due to undiagnosed mental health need.

7.3 Frontline staff to contact SCT to provide verbal handover as well and / or create an opportunity for SCT to be present for a 3way conversation with CAMHS.

7.4 At this point – SCT starts the "48hour" (2 working days) clock regarding escalation to Associate Director of Nursing for Safeguarding Children.

7.5 **(Day 1)** by 4hours from notification:

- ✓ SCT to ascertain which professionals are involved.
- ✓ SCT to review records to ascertain what actions have been taken and need to be taken.
- ✓ Ensure staff have made all the relevant referrals.
- ✓ Ascertain whether CAMHS referral has been accepted and there is a record of CAMHS action plan in PRUH records.
- ✓ Is there a clear record of handover between CAMHS and PRUH frontline staff?
- ✓ SCT to inform the Associate Director of Nursing for Safeguarding Children.

7.6 If 4th hour is after 16.30: SCT to ascertain what the plan is for discharge by 10.00 am the following working day.

7.7 If 4th hour is before 13.30: SCT to ascertain what the plan is for discharge by 15.30.

7.8 (**Day 1/Into Day 2)** If there is no action plan by 6th hour – SCT to initiate an e-mail trail with the respective multiagency professionals requesting an outcome of assessment and roles being undertaken (i.e.) action plan. The e-mail will include the following parties:

- ✓ Associate Director of Nursing for Safeguarding Children.
- ✓ Head of Nursing for Mental Health
- ✓ Head of Nursing for Children's and Young People
- ✓ Head of Nursing for Adult ED and Acute Medicine
- ✓ Respective Matrons/Nurse in Charge

7.9 E-mail will be generated using generic email address for each external multiagency group which needs to attend. The respective multiagency representatives involved with the development will determine who needs to have access to this generic email address, they will be responsible for ensuring there is a SPOC identified – so that when an SCT sends the email – the SPOC takes on responsibility for identifying which specific practitioner needs to respond.

7.10 (**Day2).** If there is an action plan, but it is unsatisfactory i.e. indicates:

- ✓ Plan does not factor in CYP is a repeat attender with a history of complex discharge/ previous discharge plan (to the same place being proposed on new admission) was unsuccessful.
- ✓ Difference in opinion in regard to discharge plan e.g., Tier 4 bed vs community follow up.
- ✓ Delayed discharge due to a lack of a suitable placement
- ✓ Discharge plan has not factored in CYP's wishes fully i.e.if they express concern about parenting capacity.
- ✓ Children Social care seeking time for legal processes to be undertaken.
- ✓ Children Social Care seeking time to enable further assessment of parenting capacity whilst CYP cannot be discharged a meeting is to be to be coordinated – to pull together an understanding of assessment taken / discharged SCT outstanding and for a robust action plan to be agreed.

7.11 SCT to coordinate meeting. To pull together an understanding of assessment taken/ outstanding and for a robust action plan to be agreed. This meeting will be influenced by a risk assessment presented by the treating clinician/consultant The Discharge Planning Meeting to take place by 15.00 of day 3.

8. Children admitted to Hospital with presenting mental health or complex needs (Bromley CSC)

8.1 The child or young person who is admitted to PRUH may be a Child in Need of services under Section 17 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 Section 47 of the Children Act 1989. In this case a Strategy Meeting will be convened by CSC with partnership agencies. The Strategy Meeting will determine if a section 47 enquiry should commence under the Children Act 1989, which may lead to further intervention by CSC.

8.2 If the child or young person is already open to Children's Social Care, or for non-statutory Early Help support or Child in Need /Child Protection statutory support and intervention concerns should be referred to the relevant CSC team, any information sharing and/or concerns should be referred to the allocated social worker or Unit. All new referrals should be made to Children and Families Hub via orders on EPR who will determine the level of response. It is important to seek consent from parents or persons with legal parental responsibility before referring to Children's Social Care (unless it is a Section 47 investigation). Based on the level of need there are likely to be one of 4 outcomes:

- ✓ Case passed to universal services for information, advice and/or support.

- ✓ Bromley CSC Early Help for support based on assessed need of the child, young person, and family.
- ✓ Case allocated for child in need assessment or child protection enquiry
- ✓ No services may be required from Children's Social Care

8.3 Out of hours at weekends, evenings and Bank Holidays the Emergency Duty Social Worker will provide the CSC response but outside of emergencies assessments and child protection enquiries will be progressed the next working day.

8.4 Children and Families Hub Managers will respond to all referrals/contacts within 24 hours of the receipt of referral/contact and on the same day for urgent, high-risk cases. The timing of response may vary depending on the assessed need and urgency.

9. The following processes will be followed:

- ✓ Hold a telephone or electronic discussion with the referrer.
- ✓ Follow the London Safeguarding Children Procedures and Bromley CSC Guidelines for Early Help and Support.
- ✓ Feedback results of enquiries to referrer and advice of actions which could be Universal services, or Bromley CSC Early Help support, Child in Need or Child Protection enquiries and assessments.
- ✓ The referral will only progress to a Child Protection Enquiry under section 47 following the need for a multi-agency Strategy Meeting that determines if CSC lead the enquiry or a joint enquiry is made with the police .
- ✓ If the child already has an allocated Social Worker, Children and Families Hub will pass the referral immediately to the allocated social worker to deal with the referral.
- ✓ 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.

10. 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 sooner, especially if discharge is imminent.
- ✓ If there are safeguarding concerns where significant harm is a concern a multi-agency Strategy Meeting will be co-ordinated by CSC in order to determine if a section 47 child protection enquiry should commence. Police, health, and education representatives must attend to ensure all information is shared to inform the decision making. A CSC Team Manager will chair the Strategy Meeting. It will be agreed if a section 47 enquiry is required as to whether this will proceed as a single agency (CSC) or joint agency enquiry (CSC/Police). The section 47 enquiries should be completed within 15 working days.

- ✓ Attend the Discharge Planning Meeting in cases where there are safeguarding concerns and a referral has been made to CSC. It is imperative that a discharge meeting is held prior to discharging the child or young person. A risk assessment from a treating clinician should be available to professionals to inform decision making at this meeting.
- ✓ 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. It is necessary that all professionals and child/young person's family as well as the young person (if age appropriate) to plan their discharge and placement options.

10.1 Further to this, if it is deemed unsafe for the young person to return home, social care and health professionals (if the health need remains a prominent concern) will discuss the need for an alternative placement. A discharge plan will be agreed by the professional network prior to discharge. If a social care provision is determined as the best place the child should be placed , the Social Care Head of Service will be informed who will consult the Assistant /Director of CSC .

11. Child and Adolescent Mental Health Services Practitioners (CAMHS OXLEAS)

11.1 All children who present to PRUH in mental health crisis will be assessed by CAMHS within 1 hour of receipt of the referral into the CAMHS Crisis team. The time to assess maybe longer where it is necessary to liaise with social care or other agencies prior to assessment, and in these instances, this will be communicated to ward staff. From March 2023, the CAMHS Crisis Team provide 24hr assessment cover Monday to Friday inclusive of bank holidays whilst continuing to provide cover on weekends between 8am-10pm. The team will expand to Monday to Sunday 24hour assessment cover by Summer 2023.

11.2 The CAMHS clinician will record a summary of the assessment on Oxleas clinical record system progress notes and ward clinical notes (CAMHS do not have access to PRUH clinical record system) to develop a joint care plan. All risks should be clearly identified and recorded. The CAMHS clinician will ensure a verbal handover of information is also given, including the plan following assessment.

11.3 The CAMHS clinician will assess the young person's competence and capacity to agree to a care plan, as part of their assessment.

11.4 Where a young person can be discharged and there is a parent/carer able to take them home, the CAMHS clinician will develop a safety plan with the young person and parent/carer and arrange follow up within the community within 7 days.

11.5 Where a young person needs an admission to a CAMHS psychiatric inpatient unit the on-call psychiatrist will attend Emergency Dept to assess the young person and the CAMHS duty senior will liaise with SLP bed management. Where compulsory admission is needed the CAMHS senior, or psychiatrist will request an AMHP for the assessment. Where a young

person is awaiting an inpatient bed the CAMHS psychiatrist/clinician will provide daily reviews prior to transfer.

11.6 Where a young person presents with complex safeguarding or social care needs alongside mental health issues, the CAMHS clinician will refer to Bromley social care if the young person is not currently known to them or contact the known social worker/team as appropriate. CAMHS will also notify the PRUH Safeguarding team. Where necessary CAMHS will request that someone from social care is able to attend any multi- agency joint assessments and explain the clinical rationale for doing so.

11.7 If a social care placement is to be sought, after the multi-agency joint assessment, CAMHS will provide a report outlining a summary of the crisis assessment, current risks to self/others, a mental state, and psychiatric recommendations, to assist the placement decision process. The report will be co-signed by the CAMHS psychiatrist and CAMHS crisis clinician and sent within 24 hours of the joint assessment (Mon-Fri). This report will be shared by email with the ward to be uploaded to PRUH clinical records system.

- ✓ Whilst a young person remains on the ward or in Emergency Dept, CAMHS will provide a daily review and discussion with the staff to support management whilst in the department as well as decision making regarding the safe discharge of children admitted with mental health needs.
- ✓ When the young person can be discharged with a parent/carer the CAMHS clinician will develop a safety plan with the young person and parent/carer and arrange follow up within the community within 7 days, as per above.
- ✓ CAMHS will attend all interagency and discharge planning meetings as invited by PRUH to facilitate the discharge of young people as appropriate.
- ✓ The purpose of this interagency agreement is to work together across Bromley CSC, PRUH, and OXLEAS CAMHS in the best interests of young people who present to A&E in mental health crisis. However, should a case need additional multi-agency thinking, please see escalation processes below.

12. The Discharge Planning Process

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

13. Agency attendances at the DPM

13.1 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/HON or their delegate; Ward Nursing Staff and if mental health and/or self- harm is involved, a CAMHS Practitioner. The

Head of Nursing for Children and Young People and Emergency Dept will also attend. If CFCS cannot attend the DPM, they will dial into the meeting.

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

13.3 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.

14. Convening/Chairing the Discharge Planning meeting

14.1 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. A risk assessment for the treating clinician should be provided to inform the meeting of decision making.

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

- ✓ PRUH/ SCTGA convene the DPM.
- ✓ Decision to be made in the first meeting regarding partner who should chaired the DPM.
- ✓ A separate professionals meeting may be required in some cases e.g., where there are threshold issues; discharge is not imminent.
- ✓ If there are safeguarding concerns for the child that may meet a child protection threshold CSC will convene a Strategy Meeting prior to discharge to determine if a section 47 (single or joint agency)should commence.

  The Strategy Meeting needs to be a standalone meeting, it is agreed that once decision is made the discharge planning meeting could follow immediately to save professional time – both elements of these meetings should be minuted as separate meetings.

15. Agenda for the DPM

15.1 The meeting will be initiated by PRUH. The hospital will chair the initial meeting and decide which partner is best placed to chair future meetings. PRUH will record and circulate the discharge plan (see Appendix 1). In cases where Children's Social Care are involved, they can hold or share the chairing responsibility.

16. The DPM will address:

- ✓ Background and reasons for admission
- ✓ Outcome of assessments

- ✓ Voice of child and their lived experience
- ✓ Develop the discharge plan.

17. The discharge plan will specify

- ✓ The identified risks, triggers, and warning signs
- ✓ Protective factors
- ✓ Safety Plan
- ✓ 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.

17.1 The Discharge Plan should be documented on the agreed template (see Appendix 1). The 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 . It will cover the following:

- ✓ 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.

17.2 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.

18. Escalation/Conflict Resolutions

18.1 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:

- ✓ Raise initial problems with a team manager/clinical lead/ or on call Manager out of Hours.
- ✓ If it cannot be resolved then problems still persist and a resolution has not been sought, then please refer to escalation protocols below (see Appendices 2 and 3).

19. 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: **Mental Capacity Act Code of Practice - GOV.UK (www.gov.uk)**

c) Mental Health Act Code of Practice (1983). Online available at: **Mental Health Act 1983 (publishing.service.gov.uk)**

d) London Safeguarding Children Procedures and Practice Guidance Updated 2nd October 2017 https://www.londonsafeguardingchildrenprocedures.co.uk/

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

f) Working Together To Safeguard Children (2018) Working Together to Safeguard Children 2018 (publishing.service.gov.uk)

g) BSCP ESCALATIONPOLICY_May_23_v1.8_100523.pdf (inzu.net)

20. 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.

London Safeguarding Children Procedures

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.

https://safeguardinghub.co.uk/gillick-competence-and-fraser-guidelines-guide-and-resources/

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. **Every child matters - GOV.UK (www.gov.uk)**

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 coordinating 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.

Appendix1 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**
Pronouns:	
DOB	**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 & phone contact**

Outcome of Assessment(s) **Hospital** **CAMHS**

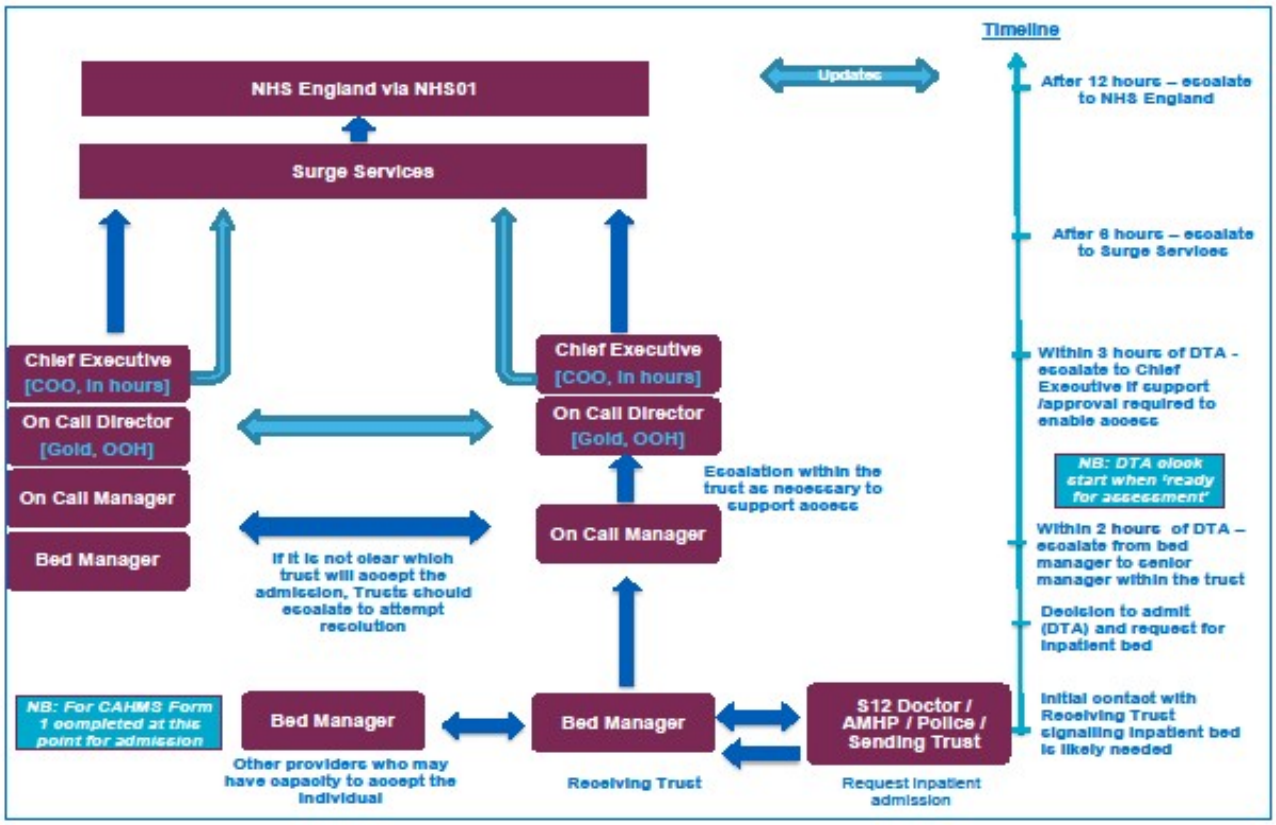
CSC **Other**
Voice of the child/young person and their lived-in-experience
Identified Risks, Triggers & Warning Signs
Protective Factors
Treatment and Support Plan: (to include medication, any additional medical or social investigations required, direct work with young person and other family members, 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 & Venue**	**Who will arrange**	

Appendix 2 – NHS England - Mental Health: Escalation when an individual is waiting for an inpatient admission

Mental Health: Escalation when an individual is waiting for an inpatient admission



1

Appendix 3 – Escalation Process: Key Contacts
OXLEAS CAMHS - Escalation Process

Monday –Friday 8am-5pm

1. OXLEAS CAMHS Crisis Duty Senior — **Contact Details**

0203 319 7666 or 0203 260 5211 oxl-tr.camhscrisisteam@nhs.net

This is on a rota basis and will be one of:

- Baba Laleye (Team Manager)
- Shirley Addo (Crisis Practice Development Lead)
- Shanice Enoe (Operational Manager)
- Dominic Leigh (Service Manager)

Please ask for the **OXLEAS CAMHS Crisis Duty Senior** in any communication

2. Crisis Operational Manager or CAMHS Service Manager

Crisis Operational Manager – Shanice Enoe — 0203 260 5211 shanice.enoe@nhs.net
CAMHS Service Manager – Dominic Leigh — 020 8319 7207 or 020 8315 4430 dominic.leigh1@nhs.net

3. CAMHS **Associate Director** – Lauren Cane — 0203 260 5175 lauren.cane@nhs.net

Mon-Fri Out of Hours 17:00-08:00 (updated 17/04/2023)	**Contact Details**
OXLEAS CAMHS Crisis Team Duty Senior	Contact via the Bracton Centre swith board 01322 294 300 and ask for the CAMHS Duty Senior / oxl-tr.camhscrisisteam@nhs.net
OXLEAS Senior Manager on Call (SMOC)	Contact via the Bracton Centre switch board 01322 294 300

LBB Children's Social Care Escalation Process

1) **Named Social Worker**

If the named Social Worker is unknown, then contact Children and Families Hub (Monday – Friday, 08.45-17:00) on mash@bromley.gov.uk or any of the following three numbers: 020 8461 7373 / 020 8461 7379 / 020 8461 7026.
For out of hours duty call 0300 303 8671.

The majority of cases will be resolved directly with the Social Worker and Team Manager for the relevant area.

2) **Team Manager** /Group Manager

3) **Head of Service**

Head of Service for Children and Families Hub, Referral & Assessment Service and EDT – Aneesa Kaprie; 0208 461 7613; Aneesa.Kaprie@bromley.gov.uk
Head of Service for Safeguarding and Care Planning West – Wendy Pullen; 020 8461 7035; Wendy.Pullen@bromley.gov.uk
Head of Service for Safeguarding and Care Planning East, and Court Team – Carol Whiting; 020 8313 4872; Carol.Whiting@bromley.gov.uk
Head of Service for Children Looked After and Care Leavers – Cathy Lloyd Williams; 0208 461 7792; Cathy.Lloydwilliams@bromley.gov.uk
Head of Service for 0-25 (including Children with Disabilities) – Mark Smith; 020 8461 7915; Mark.Smith@bromley.gov.uk

4) **Assistant Director**

Assistant Director of Safeguarding and Care Planning – David Dare; 020 8461 7465; David.Dare@bromley.gov.uk
Assistant Director of Specialist Services – Vicky West; 020 8461 7219; Vicky.West@bromley.gov.uk

PRUH: Children and Young People Escalation Process

Head of Nursing for Mental Health	Kieran Quirke kieran.quirke@nhs.net 07501121071
Head of Nursing for Children's and Young People	Sarah Harris sarahj.harris@nhs.net 07957567423
Head of Nursing for Adult ED and Acute Medicine	Kirsty Fulton kirsty.fulton3@nhs.net 01689863000 ext. 63977
Respective Matrons/Nurse in Charge	David Crichton david.crichton3@nhs.net 07845289222

Emergency Dept Staff

Service manager/ Assistant service manager	Anastasia Ustinova 01689863000 ext. 63721 a.ustinova@nhs.net
	Jade Davies 01689863000 ext. 63721 jade.davies10@nhs.net

Out of Hours -

On-Call Clinical Site Manager	01689 863810
SMOC Senior Manager on Call	01689863000
Director on Call DOC	01689863000

Inpatient areas

Clinical Site Manager	Greg Jackson ext. 65441 greg.jackson@nhs.net