Tiered System Support for Children and Young People in Psychosocial Crisis Without Physical Health Needs in Acute Hospital Settings V1.0

Document reference code: OP/120/24

This is a joint policy between Cornwall Partnership NHS Foundation Trust and Royal Cornwall Hospitals NHS Trust.

Purpose:
This joint policy sets out an agreement to work as an integrated system to find and operationalise solutions and onward plans for those children and young people with mental health, emotional and care needs who remain admitted to acute hospital settings without ongoing physical healthcare needs.

The principles, values and processes should be used for any delayed discharge of a child or young person who is in an unsuitable setting for their needs. This would include (but is not limited to) Section 136 suites and temporary care placements.

At all times and in all settings the best interests of the child or young person must be central.

This joint policy and procedure is an agreement that the respective agencies and organisations will work together to find creative system solutions. It also aims to outline and standardise the approach across the Southwest region while recognising and supporting appropriate local variation.

Target audience:
Trust staff, those working in the Emergency Department who are caring for children and young people.

Document author and role: Graham Garside (CAMHS Acute Services), Jane Walker (CFT Safeguarding), Anna Chick (RCHT Paediatrics), Dr Mark Jadav (RCHT ED), Wendy Perkin (RCHT Safeguarding), Sarah Goddard (CFT CYPFS), Kate Wilson (CC Social Care). Initial template by Dr Geoff Woodin (On behalf of the SWPC and NHSE SW).

Document authors contact details: 01872 253219.
Document definition: Policy.
Supporting committee: Children and Young person's clinical quality and governance group.
Chairperson: Sarah Goddard, Associate Director Children Services
Executive director responsible for the policy: RCHT Chief Nurse and CFT Chief Medical Officer.
Freedom of information: Can be released under the Freedom of Information Act 2000

CFT Document section: Clinical, operating procedures.

Audience:

☒ Cornwall Partnership NHS Foundation Trust

☒ Royal Cornwall Hospitals NHS Trust

Key words: Tiered system support, children, young people, psychiatric crisis, social crisis, MARRS, CAMHS, social care.

Approval process

Approved at: Royal Cornwall Hospital Trust, Cornwall Council, Cornwall Foundation Trust, NHS Cornwall and Isles of Scilly Integrated Care Board, Southwest provider collaborative.
Date approved: 18 July 2024
Executive approval: Dual Chief Nursing Officer / Deputy CEO RCHT.
Date approved by: 18 July 2024
RCHT General manager confirming approval processes: Rachel Pearce..
RCHT Governance lead confirming approval process: Paul Evangelista.
Review date: **Date**: 31 January 2027.
(6 months prior to the expiry date).
Expiry date: **Date**: 31 July 2027.
(normally 3 years after ratification unless there are changes in legislation, NICE guidance or national standards or the document should only be valid for a specified period).

Publication location:

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RCHT Document Library folder and sub-folder: Clinical / Emergency Department.

Version control

Version	Date	Author and/or reviewer	Section	Changes (key points)
V1.0	01/12/2023	Dr Mark Jadav		New.

This document Replaces:
Referral of Children With Back Pain to Physiotherapy Services at RCHT and CFT Clinical Guideline V1.0

Contents

Data Protection Act 2018 (UK General Data Protection Regulation Legislation)

The Trusts have a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opted in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679, contact the Information Governance team.

- Cornwall Partnership NHS Foundation Trust: Email cpn-tr.infogov@nhs.net
- Royal Cornwall Hospitals NHS Trust: Email rch-tr.infogov@nhs.net

1. Introduction

This Joint policy and procedure document sets out an agreement to work as an integrated system to find and operationalise solutions and onward plans for those children and young people with mental health, emotional and care needs who remain admitted to acute hospital settings without ongoing physical healthcare needs.

The principles, values and processes should be used for any delayed discharge of a child or young person who is in an unsuitable setting for their needs. This would include (but is not limited to) Section 136 suites and temporary care placements.
At all times and in all settings the best interests of the child or young person must be central.

This policy sets the terms and understanding between the following parties:

Category	Trust
Acute Hospital Trust	**Royal Cornwall Hospitals NHS Trust**
Local Authority	**Cornwall Council**
Child and Adolescent Mental Health Provider Trust	**Cornwall Partnership NHS Foundation Trust**
Integrated Care board	**NHS Cornwall and Isles of Scilly Integrated Care Board**
Provider Collaborative	**Southwest Provider Collaborative**

1.1 Background

There has been a national increase in the number and complexity of children and young people (CYP, for this purpose under 18 years old) presenting to acute hospital settings in psychosocial crises. There are several complex drivers of this culminating in an increase in prevalence of mental health conditions in this cohort from 1 in 10 in 2017 to the current estimate of 1 in 7 The Royal Colleges of Emergency Medicine, Paediatrics and Child Health, and Psychiatrists recognise the enormous toll that the Covid pandemic has taken on the mental health of CYP across the country. We are seeing more patients in distress

and with mental ill health, accessing services at more advanced stages of illness. We know more CYP are presenting to Emergency Departments with complex psychosocial crises with both physical and mental health needs or simply because it is the safest place for them at that moment in time.

Regardless of where CYP present for care or what their specific health needs are, we must work together to ensure they receive the highest quality evidenced based care, as quickly as possible.

Alongside this there have been recent changes to legislation which, while in the best interests of CYP, has led to a dramatic reduction in available social care settings for those CYP needing to be cared for away from their family homes.

The NHS's Long-Term Plan and Health and Care Bill 2023 are major drivers for the development of local and regional clinically led integrated systems of commissioning and delivering healthcare. There is a requirement, but also an opportunity, for agencies, providers and commissioners to come together to find solutions and design services for CYP who's needs are not easily met by current structures. There is general recognition that the process of 'escalation calls' is no longer fit for purpose.

This joint policy and procedure is an agreement that the respective agencies and organisations will work together to find creative system solutions. It also aims to outline and standardise the approach across the Southwest region while recognising and supporting appropriate local variation.

2. Scope

All Trust staff involved in the care of children and young people within the Emergency Department and within the acute hospital setting.

3. Definitions and Glossary

- CYP – Children and young people.

- ED – Emergency Department with the acute hospital setting.
- NHS – National Health Service.
- MARRS – Multi Agency Rapid Response Service.
- THRIVE model of care – The THRIVE Framework provides a set of principles for creating coherent and resource-efficient communities of mental health and wellbeing support for children, young people, and families. It aims to talk about mental health and mental health wellbeing help and support in a common language that everyone understands. The Framework is needs-led which means that mental health needs are defined by the children, young people, and their families, alongside professionals, through shared decision making. Needs are not based on severity, diagnosis, or care pathways.
- CAMHS – Child and Adolescent Mental Health Services.
- NHSE – National Health Service Executive.
- MOU – Memorandum Of Understanding.
- ICB – Integrated Care Board.

4. Ownership and Responsibilities

RCHT Chief Nurse.
CFT Chief Medical Officer.
Southwest Provider Collaborative Clinical Director.
Children's Social Services System Lead.

Authored by:
Dr Geoff Woodin (on behalf of the SWPC and NHSE SW)
In collaboration with representatives from all systems in the NHSE SW footprint:

- Gloucestershire.
- BaNES, Swindon and Wiltshire.
- Bristol, North Somerset and South Gloucestershire.
- Somerset.
- Devon.

- Dorset.
- Cornwall.

“Level 0” developed through local community of practice.

5. Standards and Practice

5.1. Agreed Principles Between All Parties

5.1.1 This policy does not predefine any specific outcome but seeks to agree a way of working across all agencies concerned to ensure CYP whose transfer to a more appropriate setting is delayed have access to the right care and support in a timely way.

5.1.2 All parties will maintain the CYP’s best interests as central to the discussions and plans and will check and challenge each other in a collegiate way where this appears to be drifting.

5.1.3 Funding should never be a barrier to delivering good and appropriate care for CYP in any setting, or to move from one setting to another.

5.1.4 It is agreed that acute hospitals play a role as a safe place for vulnerable and at risk children and young people but that this needs to be a ‘last resort’ or ‘least worse’ option.

5.1.5 All parties will ensure that they will raise awareness to other partners of their individual and collective resources, constraints and legal frameworks through regular engagement meetings outside of this structure. This will ensure that conversations are focussed on the CYP’s needs rather than service and agency dilemmas.

5.1.6 The policy outlines an agreed tiered process of system supports, within agreed timeframes and with system specific joint assessments of needs to ensure a joined up systemic approach and mutual support to finding solutions.

5.1.7 All systems will have in place an agreed tiered system support structure as described below. Within this there will be named roles and current contact details which will be revised at least quarterly with the whole process being reviewed at least annually to ensure it remains fit for purpose and effective.

5.1.8 All agencies will ensure timely and appropriate attendance at relevant system support meetings, and all concerned will engage with each other in line with the agreed values below.

5.1.9 Early in the process a 'lead agency' will be identified. This is the provider agency who is the most likely to lead on the onward placement of the child or young person. This does not preclude multiagency cooperation and joint working and can change during the process if the identified needs indicate this.

5.1.10 All meetings described herein will have brief minutes taken by lead agency and an action tracker with timings to complete identified actions distributed to all present within 24 hours of the meeting.

5.2. Agreed Values

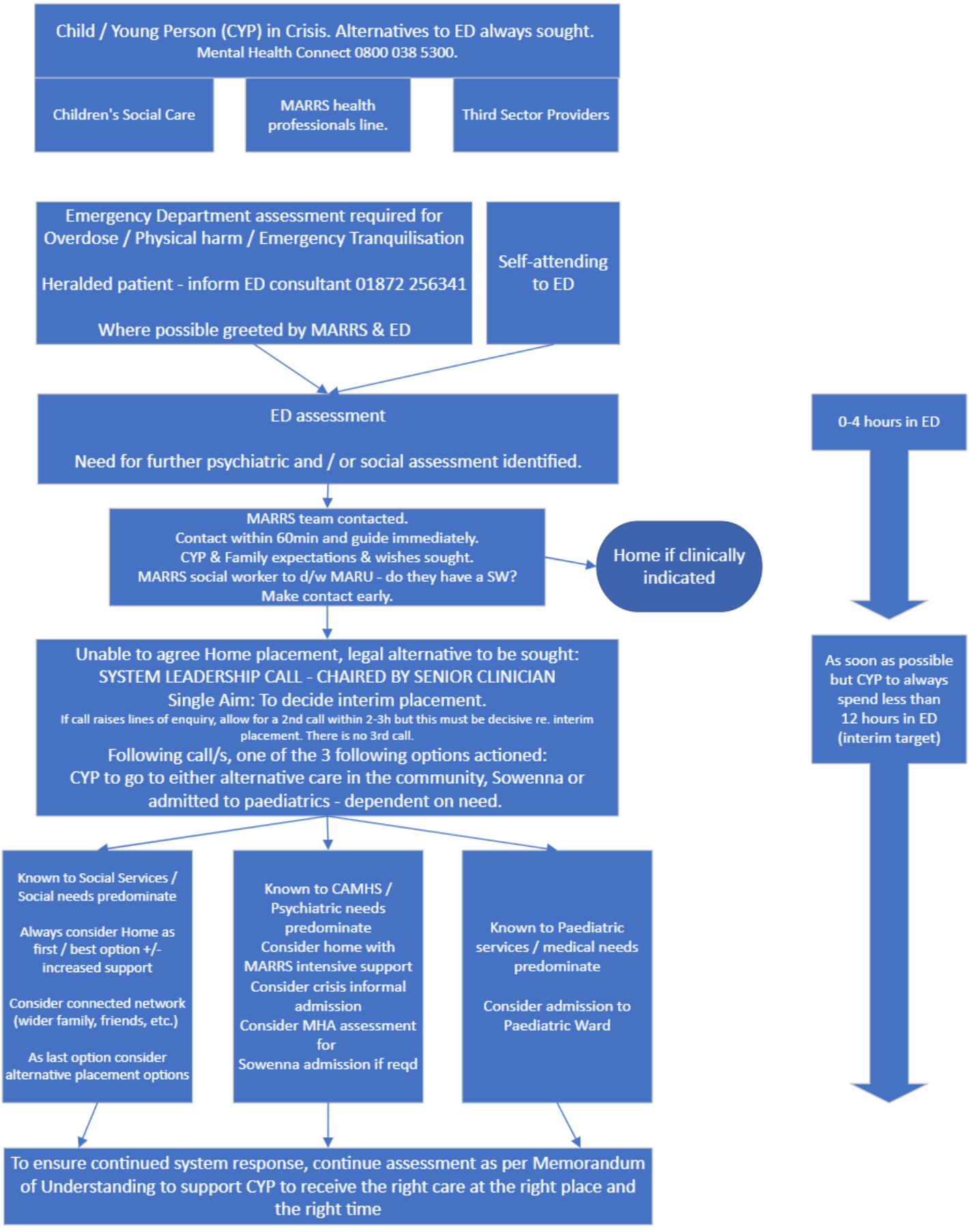
The following values underpin all interactions, at all levels, between the parties. By adhering to these we ensure that the needs and best interests of the child or young person remain at the centre of all we do. Creating organisational cultures that are aligned to these principles also ensures that conversations and solutions are collaborative and mutual support is ensured. The principles are aligned to the THRIVE model of care where the overarching principles are that the child or young person is 'our' responsibility and they have a voice in decisions made.

- **Needs based:**
  - Our approach to supporting children and young people will be based on meeting need, not diagnosis or severity.
- **Shared decision making (Participation):**
  - We will ensure that voice of the child or young person and their family are listened to and kept central to solutions identified and involved in the decision making . We will ensure they are informed of options and progress made. We and will ensure this is documented
- **Outcome-Informed:**
  - We will ensure we provide clarity and transparency from outset around options and their potential outcomes for the child and young person.
- **Accessibility:**
  - Ensure that we work together to identify and implement plans and options in a timely way with the child or young person wherever they are.
- **Solution focused:**
  - We will remain proactive in identifying solutions and overcoming challenges.
- **Partnership Working:**
  - Effective cross-sector working, with shared responsibility and risk, accountability, and mutual respect.
- **Common Language:**
  - We will seek clarification and ask questions of each other to ensure we understand each other. This includes organisational processes, methods of working and legal and statutory frameworks.
- **Shared decision making (Partnership):**
  - As partners in a system, we will ensure that we listen to the voice of each other and are all informed of options and actively involved in the process.
- **Reducing Stigma:**
  - Supporting the child or young person’s mental health is everyone’s business.
- **Proactive Prevention and Promotion:**
  - In our planning we will build on the child or young person’s strengths including safety and risk planning where relevant.

5.3. Level 0 Actions Prior to Escalation

Young people under this framework that have been assessed within the Emergency Department, should be seen, and then assessed by MARRS (Multi Agency Rapid Response Service) when medically suitable within 4 hours of presentation. Where discharge/transfer is not possible within the time frame local systems will come together to find a solution as indicated in the flow chart below.

Flow chart is on the next page.


Child / Young Person (CYP) in Crisis. Alternatives to ED always sought.
Mental Health Connect 0800 038 5300.
Children's Social Care
MARRS health professionals line.
Third Sector Providers
Emergency Department assessment required for Overdose / Physical harm / Emergency Tranquilisation
Heralded patient - inform ED consultant 01872 256341
Where possible greeted by MARRS & ED
Self-attending to ED
ED assessment
Need for further psychiatric and / or social assessment identified.
MARRS team contacted.
Contact within 60min and guide immediately.
CYP & Family expectations & wishes sought.
MARRS social worker to d/w MARU - do they have a SW?
Make contact early.
Home if clinically indicated
Unable to agree Home placement, legal alternative to be sought:
SYSTEM LEADERSHIP CALL - CHAIRED BY SENIOR CLINICIAN
Single Aim: To decide interim placement.
If call raises lines of enquiry, allow for a 2nd call within 2-3h but this must be decisive re. interim placement. There is no 3rd call.
Following call/s, one of the 3 following options actioned:
CYP to go to either alternative care in the community, Sowenna or admitted to paediatrics - dependent on need.
Known to Social Services / Social needs predominate
Always consider Home as first / best option +/- increased support
Consider connected network (wider family, friends, etc.)
As last option consider alternative placement options
Known to CAMHS / Psychiatric needs predominate
Consider home with MARRS intensive support
Consider crisis informal admission
Consider MHA assessment for Sowenna admission if reqd
Known to Paediatric services / medical needs predominate
Consider admission to Paediatric Ward
To ensure continued system response, continue assessment as per Memorandum of Understanding to support CYP to receive the right care at the right place and the right time
0-4 hours in ED
As soon as possible but CYP to always spend less than 12 hours in ED (interim target)

5.3.1. Prior to attending ED, all relevant alternatives should be considered. Mental Health Connect line, MARRS health professionals' line, Children's Social Care and other providers are all available and should be contacted from the community before sending a child or young person to ED.

5.3.2. Following attendance to the ED, and recognition that a CYP is in psychosocial crisis, a referral is to be made to MARRS by calling 01208 251300 (Bodmin Switchboard), ask to be put through to MARRS.

5.3.3. MARRS to respond to a referral within 1 hour and can often provide guidance earlier than this.

5.3.4. The expectations and wishes of the Child / Young Person and their family / carers must be sought.

5.3.5. If the CYP is likely to be known to children's social services, the MARRS social worker should contact MARU to get details of specific workers involved. Early engagement of all services allows proper exploration of options.

5.3.6. Following assessment, the plan for the next stage of care is to be shared with all that are involved in the young person's care.

5.3.7. If patient cannot be discharged safely home from Emergency Department (ED) consider the legal alternatives:

- Consider alternative community placement or additional support in the home (Positive Support Workers and/or MARRS)
- Consider crisis admission to Sowenna.
- Consider short admission to Inpatient Paediatric ward.

5.3.8. Where there is no early agreement, these will need to be discussed on a SYSTEM LEADERSHIP CALL.

5.3.9. This will be an MS Teams call set up by the ED service manager / delegated representative.

5.3.10. If the CYP attends ED between 5pm-7am, the SYSTEM LEADERSHIP CALL should be held by 11am.

5.3.11. The following representation must be present:

- The MARRS Team Lead.
- The most senior appropriate representative for Children's Social Care.
- A senior clinician from Inpatient Paediatrics.
- a member of RCHT Child Safeguarding.
- An ED senior clinician.
- Or their delegated representatives.

5.3.12. The call should be chaired by a senior clinician or social worker involved in the child / young person's case.

5.3.13. The SYSTEM LEADERSHIP CALL has a single Primary Aim: to determine the interim placement for the child / young person which will allow them to have such further / ongoing assessment and intervention as may be needed.

5.3.14. If the first call raises lines of enquiry which should reasonably be followed before a decision is made, then a second call may be agreed. This should be within the same working day (9-5) and no more than 2-3h after the first call.

5.3.15. The decision MUST be reached within the working day, with enough time to implement the recommendation before 5pm.

5.3.16. No third call can be allowed.

5.3.17. If the placement involves the CYP leaving hospital, failure to complete this MUST be considered at the system leadership call and a robust plan-B MUST be decided.

5.3.18. The aim of this Level 0 pathway is that no child should spend more than 12 hours in an emergency department. This is achievable through proactive multi-agency working.

5.3.19. No Child or Young Person should ever spend more than one consecutive night in an emergency department. This is a serious, avoidable failure of the responsibility of health and social care providers to that child and will no longer be considered. Alternatives as per 5.5.7 above must be found.

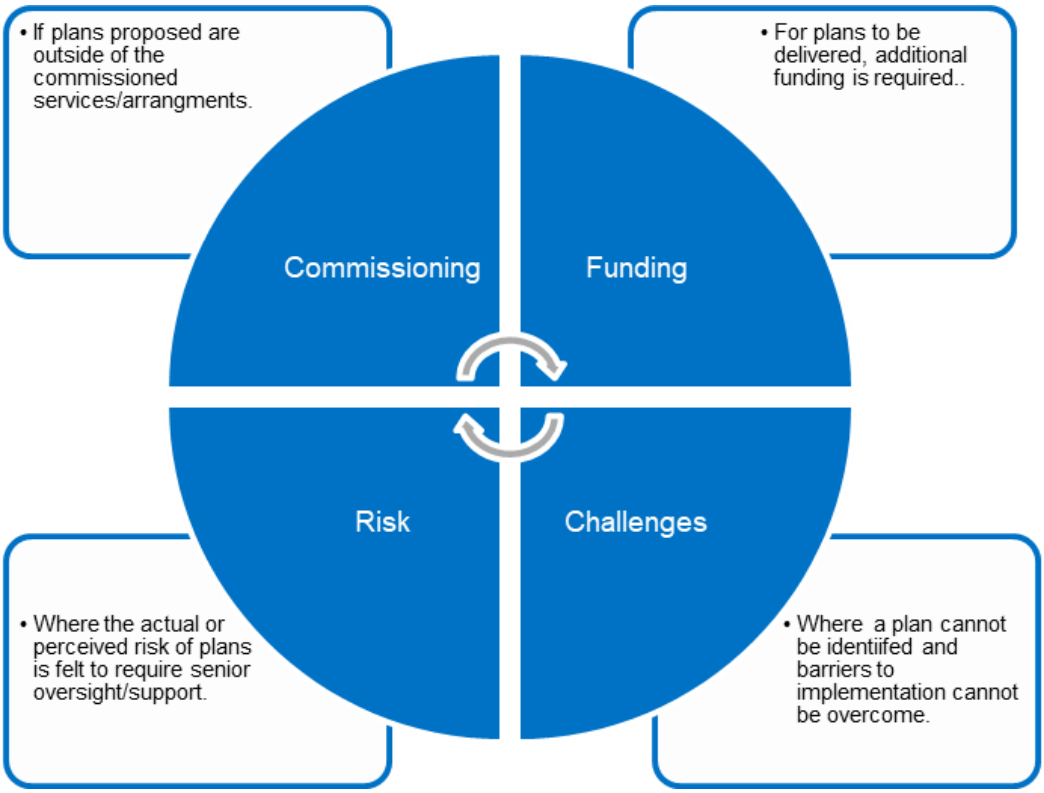
5.3.20. 24 hours after attendance and admission to an Acute Hospital (taken from the first attendance time), the MOU process should be followed as detailed below to ensure no one agency is left alone and we continue to work as a system to support the child / young person and their family. Staff that attend the meetings under the MOU need to be at a Senior level to be able to make decisions for their organisation.

5.4. Policy Process

This does not replace the usual process of appropriate single and multiple agency assessment, treatment, and care of CYP in acute hospital and other settings. This process comes into effect when these fail to deliver the appropriate outcome; timely transfer to a more appropriate setting, usually their originating care setting/home.

Timeframes are described and agreed but these are not the primary drivers for system working rather the needs assessment is central to effective cross agency working.

There are four main, interconnected areas where others may need to be involved in addition to clinical and operational leads (Level 1), see figure below:



5.5. Level 1 System Support

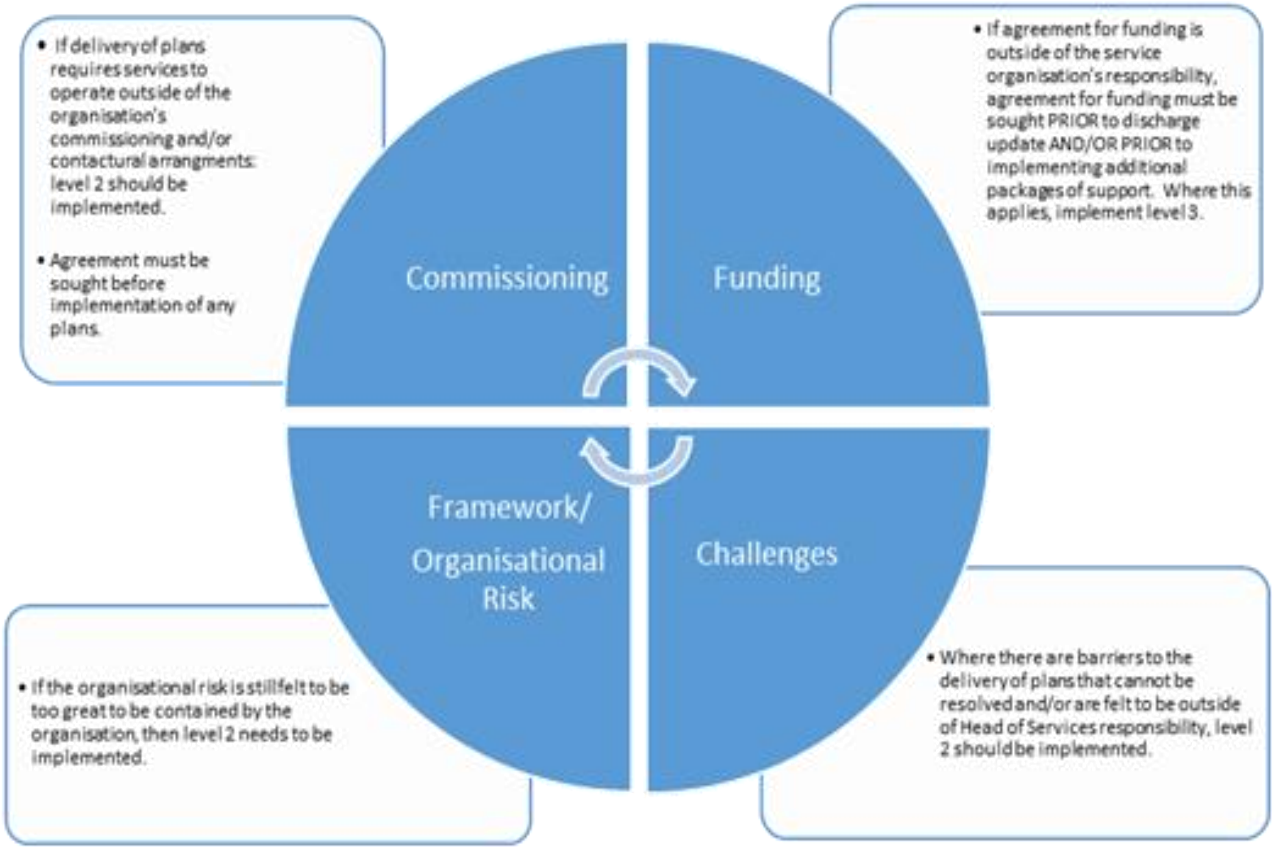
5.5.1. Once it is agreed across all agencies that the CYP requires a transfer to a more appropriate setting for their needs there will be a joint (Social Care and CAMHS) assessment of the CYP's needs and risks.

5.5.2. Within 24 working hours (i.e., excluding weekends and Bank Holidays) from the time that a CYP's needs are no longer met in the current setting and is ready for transfer a meeting will be convened to include:

- Acute Hospital Service Manager (if currently placed there).
- MARRS Team Manger.
- MARRS Social Care Manger / or Social Worker if allocated one.
- If already referred to a CAMHS inpatient unit the Provider Collaborative Case Manager.
- If appropriate the CETR lead from the ICB.

- Additional attendees appropriate to the clinical situation (e.g., parents/carers, support staff, etc.).

5.5.3. The meeting should be chaired and convened by the lead provider agency. If this is unclear the initial meeting will be chaired by the acute hospital clinician or manager and the lead agency identified in the initial meeting.



5.6. Level 2 System Support

5.6.1. Once it is agreed that system support at level 1 is unlikely to locate a solution and within 72 working hours a meeting must be convened to include:

- CAMHS Operational Manager/Head of Service.
- Local Authority Service Manager/Head of Service.
- Acute Trust Site Manager/Head of Service.
- If already referred to a CAMHS inpatient unit the Provider Collaborative

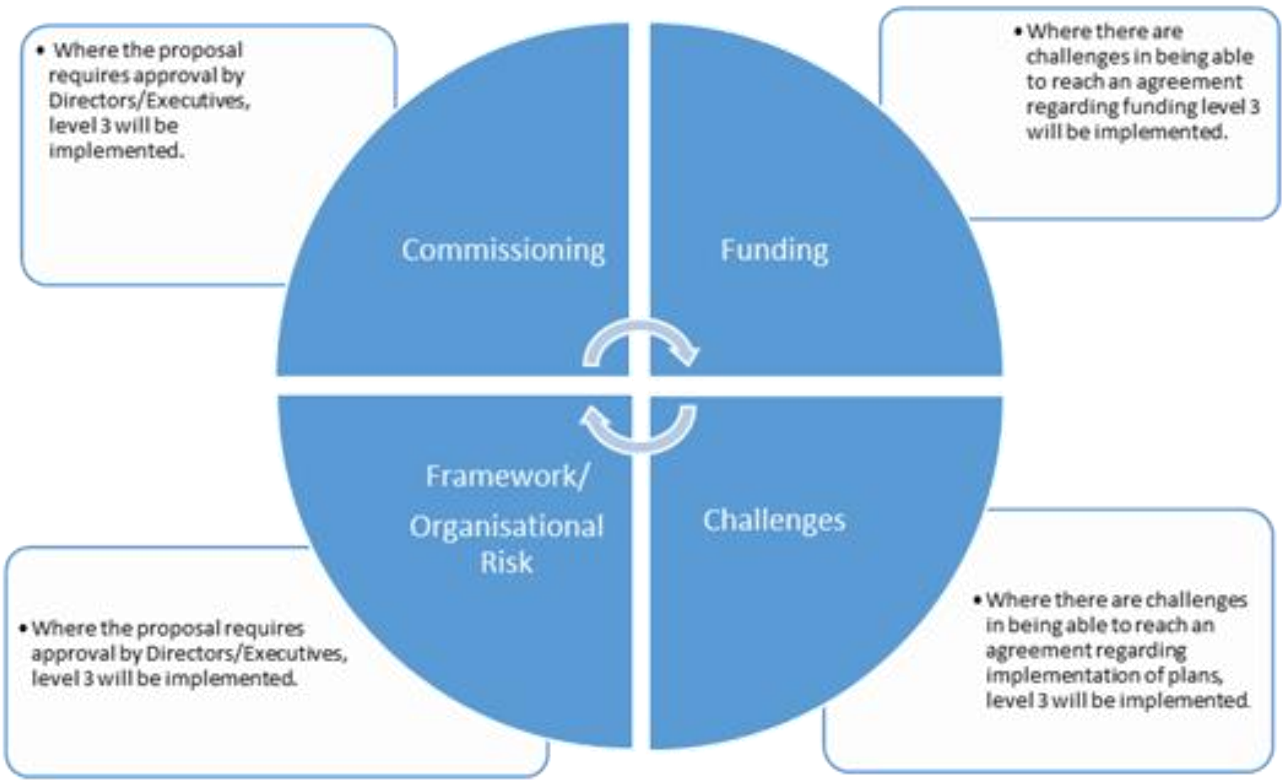
Head of Service and/or Clinical Lead.

- If appropriate Heads of Local Authority commissioning and/or ICB additional attendees appropriate to the clinical situation and needs.

5.6.2. The meeting should be chaired by the lead provider agency Head of Service or Clinical Lead, as identified at the Level 1 meetings.

5.6.3. This level aims to bring a wider perspective and additional resources to bear in finding appropriate solutions.

5.6.4. If appropriate and agreed by all agencies further Level 1 or Level 2 meetings may occur to progress a solution.



5.7. Level 3 System Support

5.7.1. Once it is agreed that system support at Level 2 is unlikely to locate a solution AND within 5 working days a meeting must be convened to include:

- Acute Hospital Trust Chief Operating Officers (or their deputy – if currently placed there).
- CAMHS provider Chief Operating Officers (or their deputy).
- Local Authority Directors of Children's Services (or their deputy).
- If already referred to a CAMHS inpatient unit the Provider Collaborative Programme Manager and/or Clinical Director (or their deputy).
- ICB Leads (or their deputy).
- Additional attendees appropriate to the clinical situation and needs.

5.7.2. The meeting should be chaired by the lead provider agency.

5.7.3. There will be an agreement around services sharing a system risk.

5.7.4. This level aims to bring wider resources not usually applicable or available to bear in identifying a solution (e.g. finances, adult and non-commissioned/regulated settings and services) OR agreeing that the current setting/situation is the 'least worst option' and needs to continue.

5.7.5. There must be a minuted, multiagency risk analysis to include clinical and operational factors that inform any decisions made.

5.7.6. Any decisions made must be communicated into the relevant agency by their representative to ensure there is clarity and to minimise repeat meetings and assessments.

5.7.7. If appropriate and agreed by all agencies further Level 1, 2 or 3 meetings may occur to progress a solution.

5.7.8. If appropriate OR if there is a risk of press interest move to the NHSE escalation or communication process.

5.7.9. While the process of this policy is underway organisations need to ensure daily contact with family whilst in the acute setting, to continue care delivery and share risks with the wider systems.

6. Related Legislation, National and Local Guidance

Mental Health of Children and Young People in England 2021 - wave 2 follow up to the 2017 survey - NHS Digital

Unregulated | Children's Commissioner for England (childrenscommissioner.gov.uk)

Joint College statement on meeting the mental health needs of children and young people in acute hospitals (rcpsych.ac.uk)

Health and Care Bill: Integrated Care Boards and local health and care systems - GOV.UK (www.gov.uk)

https://tavistockandportman.nhs.uk/our-models-of-care/thrive/#:~:text=The%20Framework%20is%20needs%2Dled,severity%2C%20diagnosis%20or%20care%20pathways.

https://implementingthrive.org/about-us/the-thrive-framework/

7. Training Requirements

Understanding of policy.

8. Implementation

Dissemination of policy through specialty leads. Discussion within specialty governance and operational fora.

9. Document Monitoring Arrangements

Information category	Detail of process and methodology for monitoring compliance
Element to be monitored	Compliance and effectiveness of policy
Lead	Head of Service, CAMHS Acute Services
Tool	Case discussion
Frequency	Bi-monthly
Reporting arrangements	Multi-agency meetings
Acting on recommendations and lead(s)	Actions as required
Change in practice and lessons to be shared	As required

10. Updating and Review

Review after 6 months and at a specified schedule thereafter. Full review after 3 years.

11. Equality and Diversity

This document complies with the Cornwall Partnership NHS Foundation Trust and Royal Cornwall Hospitals NHS Trust equality and diversity statements. The statements can be found in the RCHT Equality Diversity And Inclusion Policy and CFT Equality, Diversity and Inclusion Statement.

The initial equality impact assessment screening form is at appendix 1.

Appendix 1: Equality Impact assessment Form

Title of policy or document for assessment: Tiered System Support for Children and Young People in Psychosocial Crisis Without Physical Health Needs in Acute Hospital Settings V1.0.

Document library section: Clinical, operating procedures.

Is this a new or existing document? New.

Date of assessment: 21 January 2024.

Person responsible for the assessment: Dr M Jadav, ED Consultant, RCHT.

What is the main purpose of the document?

An agreement to work as an integrated system to find and operationalise solutions and onward plans for those children and young people with mental health, emotional and care needs who remain admitted to acute hospital settings without ongoing physical healthcare needs.

Who is affected by the document?

☒ Staff ☒ Patients ☐ Visitors ☒ Carers ☐ Other ☐ All

The document aims to improve access, experience and outcomes for all groups protected by the Equality Act 2010.

Concerns

Are there concerns that the procedural document could have a differential impact on the following areas?

If a negative impact has been identified, please complete a full EIA by contacting the Equality, Diversity, and Inclusion Team. For RCHT please contact rcht.inclusion@nhs.net and for CFT please contact cft.inclusion@nhs.net

Concern area	Response	If yes, what existing evidence (either presumed or otherwise) do you have for this?
Age	☒ Yes ☐ No	Whilst this policy aims to improve the experience of Children and Young People with psychosocial crisis presenting to acute hospitals, it is recognised that there are insufficient specific services or assessment areas for adolescents aged 16-18 and therefore they may not gain the same benefits.
Disability	☐ Yes ☒ No	
Sex	☐ Yes ☒ No	
Gender reassignment	☐ Yes ☒ No	
Pregnancy and maternity	☐ Yes ☒ No	
Race	☐ Yes ☒ No	
Religion and belief	☐ Yes ☒ No	
Sexual orientation	☐ Yes ☒ No	
Marriage and civil partnership	☐ Yes ☒ No	
Groups at risk of stigma or social exclusion such as offenders or homeless people	☐ Yes ☒ No	
Human rights	☐ Yes ☒ No	

Are there any associated objectives of the document? If yes, what existing evidence (either presumed or otherwise) do you have for this?

No.

Signature of person completing the equality impact assessment:

Name: Dr M Jadav, ED Consultant, RCHT. **Date**: 18/05/24.