**Support for children and young people in long term hospital stay**

**Scope and purpose of this policy**

This policy sets out the role of children’s social care in circumstances where a child or young person has a period of 12 weeks or longer in a hospital setting or spends any time in a Tier 4 hospital setting as a consequence of issues with their mental health. As with all work with children and families the specific focus of the work will be informed by a clear assessment of need. This assessment will consider how the admission will impact on the child and wider family. It is acknowledged that this will be a complex interplay of different factors, e.g. admission to hospital resulting from a physical health need, particularly where this is in relation to palliative care are likely to impact on a child/young persons emotional well-being.

The role of children’s social care in these circumstances is to work as part of the wider multi-agency response in order to

* Ensure that the family have sufficient support given the additional caring responsibilities. This will include consideration of the impact on other siblings in the family.
* Contribute to the planning for discharge, including consideration of ongoing support needs
* Highlight any concerns about the standards of care or support provided by the establishment and where these are identified ensure robust action is taken to address these issues.

Where a child or young person has an entitlement to S117 aftercare (see below) Children’s social care will remain involved until it is formally agreed that the young person no ;longer requires this support.

**Legal Framework**

The legal framework underpinning this policy is based on the Children act 1989 and Mental Health act 1983

**Children Act 1989 – Section 85**

Section 85 of the Children Act 1989 places a duty on local authorities to check on the safety and welfare of children living in residential education or hospital provision for any continuous period exceeding and/or likely to exceed 12 weeks.

The intention behind the legislation is to provide a ‘safety net’ for vulnerable children living away from home where the child is not accommodated under section 20 and where the child is not subject to the usual processes of Care Planning and review by an Independent Reviewing Officer.

**Mental Health Act 1983 – Section 117**

Section 117 of the Mental Health Act 1983 (MHA) places a statutory duty upon local authorities and the ICB to plan and provide mental health after care for those detained in hospital under a treatment section of the MHA (section 3, 37, 45A, 47 and 48) and includes children and young adults.

The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (2018) states that “ICBs and Local Authorities (LAs) should have in place local policies detailing their respective responsibilities, including funding arrangements”. The Practice Guidance (paragraph 64.2) states that “LAs and ICBs should have agreements in place detailing how they will carry out their Section 117 responsibilities, and these agreements should clarify which services fall under Section 117 and which authority should fund them”.

**Prior to admission**

Where a child or young person presents with complex mental health needs and there is serious concern about the risk to life or they appear to be having a psychotic episode there should be immediate liaison with the CAMHS Intensive Community Support Team.

**At the point where has been identified as being requiring hospital treatment**

Where a child who is already open to Children’s Social Care is admitted into hospital in either of the circumstances set out above the principles and expectations set out in this policy will be factored into the ongoing support for the child and family. The only exception to this would be that Section 85 of the Children act does not apply where a child is in Local Authority care.

Where a contact is made to the Multi-Agency Safeguarding Hub (MASH) relating to either of the scenarios above this will be immediately transferred to the Assessment service who will undertake the initial child and Family Assessment.

The only exception to this will be for children admitted into hospital under a treatment section of the metal Health act, which brings with it an entitlement to S117 support. Given this will trigger longer term support need children in these circumstances will immediately transfer to a Help and Protection team.

**Support**

The assessment will inform a plan that will be incorporated into the wider plan for the child but will set out the specific contribution of children’s social care. All children who fall within the scope of this family will deemed children in need. As with any young person should there be a resource implications this would ned to be authorised by a manager of sufficient seniority prior to this being agreed.

Visiting frequency will ordinarily be at the same levels as for any other child. It is recognised however that children who fall within the remit of this policy may require a more bespoke support plan.

This will be particularly the case for any child or young person who is in hospital due to concerns relating to their mental health. There may be periods where the child’s health need is in some form of crisis which would make visiting inappropriate.

We will take a needs led approach to visiting patterns. The visiting pattern will be made clear to the family and wider agency team and be subject to ongoing review. The Service Manager responsible for the social work team supporting the child will record the visiting pattern, and rationale for this, on the child’s file.

**Ongoing review**

Given the multi-agency dimension of the support for the child reviews will involve all key agencies involved. It is important to identify how the child’s school will remain engaged in this process. Where the child does not have an allocated school the Social Worker will liaise with the Virtual School to identify how the child/young person’s education needs will be addressed.

 Unless the child is subject to a protection plan, where the frequency of reviews will be in accordance with the requirements of Working Together to Safeguard Children, the frequency of reviews will also be needs led. Where reviews are held at frequencies outside of the usual Child in Need frequency the Service Manager will again record this and the rationale.

Where there is a Care, Education and Treatment Review (CETR) or Multi-Disciplinary Team (MDT) in place the Child in Need review will be incorporated into that process. It will be the Social Workers responsibility to ensure the review is recorded in MOSAIC.

**When a preparation is underway for a child to leave hospital**

Planning for a child/young person leaving hospital should begin at the point that they are first admitted and should continue throughout their time in hospital in accordance with the review process set out above.

Where the plan is for the child to return home, or to another family member the final review before the discharge point will identify what ongoing support will be provided. Unless the child is entitled to S117 aftercare support it may be that social work input will not be required beyond the period of hospitalisation. Further detail is provided about S117 support is set out in appendix 1 to this policy

Where the child/young person is moving into any setting outside of the family home it is essential that early agreement is reached about

* Which organisation will take the lead in identifying the placement
* How this will be funded

Initial discussion will place in the reviews referred to above. Should the review conclude that this is a social care led discharge plan, or something requiring joint funding, the Social Worker would not have authority to agree to such a discharge plan. Given this the child’s circumstance will be considered in the weekly Legal Gateway panel for Head of Service/Strategic Lead sign off. The Head of Legal Services (Adult Social Care) will be invited to this meeting as they lead on S117 on behalf o f the council.

Final decisions for any jointly funded support will be made in the Joint Resource Panel.

**Children aged 16/17**

If a young person in a hospital setting is thought to require support beyond their 18th birthday careful planning for the transition will be required. When the young reaches the age of 17 ½ a referral to adult social care will be made via the on-line portal. A decision will be made about which team will take the lead from adult services in the transition planning.

The young person will remain a child in need until they reach 18 years of age. The allocated Social Worker will continue to be the lead practitioner but will co-work with the identified adult lead.

Adult colleagues are involved in the monthly meeting re young people in tier 4 provision which will support their transition planning.

**Ensuring good standards of care**

Social workers should apply the same degree of vigilance when visiting a child who is in hospital care that they would apply when visiting any child in an institutional setting. This would include reviewing records, particularly those that relate to any significant incident involving the child.

Any concerns would initially be addressed with the provider and explored in the review process referred to above. If it is felt these concerns need to be escalated issues relating to in patient facilities such as hospitals or community setting would be shared with South Yorkshire Integrated Care Board (ICB) who would advise on next steps.

For children in Tier 4 provision the point of escalation would be the monthly Tier 3 meeting. Concerns would be shared the NHS South Yorkshire Collaborative.

Where concern is identified in relation to the suitability of a member of staff the Social Worker would inform the provider about their concerns and agree who will make a referral to the Local Authority Designated Officer (LADO). This would be the LADO in the area that the setting is based in.

**Case holding responsibility**

Children and young people who already have an allocated social worker will remain allocated to that worker. Where new referrals are received they will be transferred by the MASH directly to Help and Protection team in the area of the City that the family live

**Appendix 1 - Section 117 Expectations**

**Ordinary Residence**

Understanding where the child is judged to be ordinarily resident is critically important in identifying which Local Authority and ICB is responsible for the ongoing support for a child and young person. This is a complex and evolving area of practice. Given the small number of children who will fall within the scope of S117 legal advice will be sought for each young person. Where a child is admitted to hospital on more than one occasion legal advice will be sought on each occasion.

**Funding**

Where there is a potential need for multi-agency funding this will follow the Joint Review Panel process. If an emergency decision is required this can be made out of panel with agreement of the chair but would need to go to the next JRP meeting for formal consideration. The briefing note for JRP will be explicit about the young persons entitlement to S117 support.

**After-care Planning**

Although the duty to provide aftercare services begins when the young person leaves hospital, planning should start as soon as possible after they are admitted. ICBs and local authorities should take reasonable steps to identify appropriate after-care services for young people in good time for their eventual discharge from hospital.

After-care should be planned within the framework of the Care Programme Approach**.**

**After-care Planning Assessment**

After-care planning requires a thorough assessment of the young person's needs and wishes. It 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 National Probation Service 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.

Professionals with specialist expertise should also be involved in after-care planning for young people with autistic spectrum disorders or learning disabilities.

After-care planning should take account of the young person's age, and should involve their parent/carer (as appropriate) to ensure that they will be ready and able to provide the assistance which the young person may need.

In order to ensure that the After-care Plan reflects the full range of needs of the young person, it is important to consider who needs to be involved. Subject to the views of the young person, this may include:

* The young person's responsible clinician;
* Nurses and other professionals involved in caring for the young person in hospital;
* A practitioner psychologist, community mental health nurse and other members of the community mental health team;
* GP and primary care team;
* Any carers who will be involved in looking after the young person outside hospital including, where relevant, those with parental responsibility;
* The patients' nearest relative or other carers;
* A representative of any relevant voluntary organisations;
* MAPPA co-ordinator if applicable;
* National Probation Service if applicable;
* A representative of housing authorities if accommodation is an issue;
* The ICB's appointed clinical representative if appropriate;
* An Independent Mental Health Advocate, if the young person has one;
* An Independent Mental Capacity Advocate, if the young person has one;
* Attorney/Deputy if applicable;
* A person to whom the local authority is considering making Direct Payments for the young person;
* Any other representative nominated by the patient; and
* Anyone with authority under the Mental Capacity Act 2005 to act on the young person's behalf.

The practitioners concerned, in discussion with the young person and their family, should agree an outline of the young person's needs and a timescale for implementing the various aspects of the Aftercare Plan. All key people with specific responsibilities should be identified.

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. If the worker will need to seek approval for this, extra time must be set aside for planning so that this causes no delay to the implementation of the after-care plan.

**The After-care Plan**

The After-care Plan (under the Care Programme Approach) aims to ensure a transparent, accountable and co-ordinated approach to meeting wide ranging physical, psychological, emotional and social needs associated with the young person's mental disorder. It should set out the practicalities of how the young person will receive treatment, care and support day-to-day and should not place undue reliance on the young person's carers.

Included within the After-care Plan are:

* A Treatment Plan which details medical, nursing, psychological and other therapeutic support for the purpose of meeting the young person's individual needs promoting recovery and/or preventing deterioration;
* Details regarding any prescribed medications;
* Details of any actions to address physical health problems or reduce the likelihood of health inequalities;
* Details of how the young person will be supported to achieve their personal goals;
* Support provided in relation to social needs such as housing, occupation, finances etc.
* Support provided by carers;
* Actions to be taken in the event of a deterioration of the young person's presentation; and
* Guidance on actions to be taken in the event of a crisis.

After-care Plans should include details of any areas of need which are critical to preventing behavioural disturbance, and should provide guidance on how staff/carers should respond if behavioural disturbance does arise.

The After-care Plan should identify a named individual as Care Co-ordinator who has responsibility for co-ordinating the preparation, implementation and evaluation of the After-care Plan.

The After-care Plan should clearly record whether the person is entitled to Section 117 aftercare and, if so, explain which care services will be funded under this section. The local authority and ICB providing the Section 117 funding should also maintain a record of what aftercare services they are providing to whom.

**Reviewing the After-care Plan**

The After-care Plan should be regularly reviewed. Eligibility for Section 117 should be reviewed within six weeks of discharge from inpatient services, then annually thereafter, or sooner if circumstances change.

It will be the responsibility of the allocated social worker to arrange reviews of the Plan until it is agreed between all parties, including the young person, that it is no longer necessary.

The After-care Plan will need to be reviewed if the young person moves to another area. The Social worker in the original area will be responsible for making transfer arrangements if commissioning responsibility consequently passes to authorities in the new area